

Medicare Program Integrity Manual

Chapter 10 – Medicare Enrollment

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10.1 – Introduction to Medicare Provider Enrollment

(Rev. 10672; Issued: 03-18-21; Effective: 03-12-21; Implementation: 03-22-21)

This chapter specifies the resources and procedures Medicare Administrative Contractors (MAC) must use to establish and maintain provider and supplier enrollment in the Medicare program. These procedures apply to the MACs and the National Supplier Clearinghouse (NSC) (hereafter occasionally referred to collectively as simply “the contractor”), unless contract specifications state otherwise.

10.1.1 – Definitions

(Rev. 10672; Issued: 03-18-21; Effective: 03-12-21; Implementation: 03-22-21)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Final adverse legal action means the following:

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

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

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

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

1. Any federal or state felony conviction(s).
2. Any misdemeanor conviction, under federal or state law, related to: (a) the delivery of an item or service under Medicare or a state health care program, or (b) the abuse or neglect of a patient in connection with the delivery of a health care item or service.
3. Any misdemeanor conviction, under federal or state law, related to the theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.

4. Any misdemeanor conviction, under federal or state law, related to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. section 1001.101 or 1001.201.
5. Any misdemeanor conviction, under federal or state law, related to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

Exclusions, Revocations, or Suspensions

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

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

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

Institutional provider means – for purposes of the Medicare application fee only - any provider or supplier that submits a paper Medicare enrollment application using the Form CMS-855A, Form CMS-855B (not including physician and non-physician practitioner organizations), Form CMS-855S, Form CMS-20134, or associated Internet-based Provider Enrollment, Chain and Ownership System (PECOS) enrollment application.

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

Managing employee means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts, the day-to-day operation of the provider or supplier, either under contract or through some other arrangement, whether or not the individual is a W-2 employee of the provider or supplier.

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

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

Operational – under 42 CFR § 424.502 – means that the provider or supplier has a qualified physical practice location; is open to the public for the purpose of providing health care related services; is prepared to submit valid Medicare claims; and is properly staffed, equipped, and

stocked (as applicable, based on the type of facility or organization, provider or supplier specialty, or the services or items being rendered) to furnish these items or services.

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

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

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

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

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

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

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

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

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

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

Reject/Rejected means that the provider or supplier’s enrollment application was not processed due to incomplete information or that additional information or corrected information was not

received from the provider or supplier in a timely manner. (See 42 CFR § 424.525 for more information.)

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

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

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

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

10.1.2 – Enrolling to Receive Medicare Payment **(Rev. 10672; Issued: 03-18-21; Effective: 03-12-21; Implementation: 03-22-21)**

No provider or supplier shall receive payment for services furnished to a Medicare beneficiary unless the provider or supplier is enrolled in the Medicare program. Further, it is essential that each provider and supplier enroll with the appropriate Medicare Administrative Contractor. We use the term “enrollment” generally to include activities a provider or supplier undertakes to enroll in the Medicare program and maintain enrollment in good standing, which includes, but is not limited to, initially enrolling, revalidating enrollment, and reporting changes of information as described within this chapter.

A. Initial Enrollment

In general, a provider or supplier shall enroll as an initial applicant if it is:

- Initially enrolling in the Medicare program or enrolling as a provider or supplier in a new geographic jurisdiction.
- Seeking to reestablish itself in the Medicare program after a voluntary withdrawal from the Medicare program, or subsequent to a termination or revocation of enrollment based upon any CMS authority under Title 42 of the CFR.

For additional information, refer to sections of this chapter concerning unique provider and supplier types, the applications that correspond to Medicare enrollment by provider/supplier type and purpose, and a general discussion of enrollment topics.

B. Revalidation

Pursuant to 42 CFR §§ 424.515, 410.41(c), and 424.57(g), providers and suppliers use the CMS enrollment application process to periodically revalidate their Medicare enrollment record. Suppliers of durable medical equipment, prosthetics, orthotics, and supplies are required to revalidate every 3 years and all other providers and suppliers every 5 years.

C. Changes of Information

Consistent with 42 CFR § 424.516, providers and suppliers use the CMS enrollment application process to report changes of information as required to remain in compliance with the requirements to participate in Medicare.

10.1.3 - General Summary of Process to Enroll in Medicare (Rev. 10672; Issued: 03-18-21; Effective: 03-12-21; Implementation: 03-22-21)

Providers and suppliers, including physicians, may enroll or update their Medicare enrollment record using the:

- Internet-based Provider Enrollment, Chain and Ownership System (PECOS), or
- Paper enrollment application process (e.g., Form CMS-855).

The Medicare enrollment applications are issued by CMS and approved by the Office of Management and Budget.

Paper applications can be accessed at the Web site <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/EnrollmentApplications.html>.

PECOS can be accessed at <https://pecos.cms.hhs.gov/pecos/login.do>.

Web Sites

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

The CMS Provider/Supplier Enrollment Web site, <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index?redirect=/MedicareProviderSupEnroll/>, furnishes the user with access to provider/supplier enrollment forms, specific requirements for provider/supplier types, manual instructions, frequently asked questions (FAQs), contact information, hot topics, and other pertinent provider/supplier information. The contractor shall not duplicate content already provided at the CMS provider/supplier enrollment Web site and shall not reproduce the forms or establish the contractor's own links to forms. It shall, however, have a link on its Web site that goes directly to the forms section of the CMS provider/supplier enrollment site.

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

URL: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/contact_list.pdf

If the contractor services several states with a universal address and telephone number, the contractor shall report that information. In situations where no actions are required, a response from the contractor is still required (i.e., the contact information is accurate). In addition, only such information that pertains to provider enrollment activity for the contractor's jurisdiction is to be reported. All updates shall be sent directly via e-mail to the contractor's CMS Provider Enrollment & Oversight Group Business Function Lead.

10.1.4 - General Overview of Medicare Enrollment Application Forms (Rev. 10672; Issued: 03-18-21; Effective: 03-12-21; Implementation: 03-22-21)

The enrollment applications are available online as well as in paper form:

A. General Overview of Form CMS-855 and CMS-20134

Each Form CMS-855 application is used to enroll a specific provider or supplier type for a specific purpose.

1. CMS-855A – Medicare Enrollment Application for Institutional Providers

This application should be completed by institutional providers (e.g., hospitals) that will furnish Medicare Part A services to beneficiaries.

2. CMS-855B – Medicare Enrollment Application for Clinics, Group Practices, and Certain Other Suppliers

This application should be completed by supplier organizations (e.g., ambulance companies) that will bill Medicare for Part B services furnished to Medicare beneficiaries. It is not used to enroll individuals.

3. CMS-855I - Medicare Enrollment Application for Physicians and Non-Physician Practitioners

This application should be completed by physicians and non-physician practitioners who render Medicare Part B services to beneficiaries. (This includes a physician or practitioner who is: (1) the sole owner of a professional corporation, professional association, or limited liability company and will bill Medicare through this business entity; or (2) a sole proprietor.) (See section 10.6.4 of this chapter for more information on the business types discussed in this paragraph.)

4. CMS-855R - Medicare Enrollment Application for Reassignment of Medicare Benefits

An individual who renders Medicare Part B services and seeks to reassign his or her benefits to an eligible entity should complete this form for each entity eligible to receive reassigned benefits. The individual must be enrolled in the Medicare program as an individual prior to reassigning his or her benefits.

5. CMS-855S – Medicare Enrollment Application for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers

This application should be completed by DMEPOS suppliers. The National Supplier Clearinghouse (NSC) is responsible for processing this type of enrollment application.

6. CMS-855O – Medicare Enrollment Application for Eligible Ordering, Certifying Physicians, and other Eligible Professionals

This form is used for physicians and other eligible professionals who wish to register in Medicare solely for the purpose of ordering and certifying the items and services described in 42 CFR § 424.507. These physicians and other eligible professionals do not and will not send claims to a MAC for any services they furnish.

7. CMS-20134 – Medicare Enrollment Application for Medicare Diabetes Prevention Program (MDPP) Suppliers

This application should be completed by any supplier organizations that will furnish and bill Medicare Part B for the MDPP services furnished to Medicare beneficiaries.

B. General Overview of Additional Enrollment Forms

The following forms or form types are routinely submitted with an enrollment application:

1. CMS-588 – Electronic Funds Transfer (EFT) Authorization Agreement

The EFT Agreement authorizes CMS to deposit Medicare payments directly into a provider/supplier's bank account.

For Form CMS-855S enrollment, CMS only requires collection of Form CMS-588 with initial enrollment applications.

2. CMS-460 – Medicare Participating Physician or Supplier Agreement

This agreement establishes that the Medicare provider/supplier accepts assignment of the Medicare Part B payment for all services for which the participant is eligible to accept assignment under the Medicare law and regulations and which are furnished while the agreement is in effect. The contractor shall explain to the provider or supplier the purpose of the agreement and how it differs from the actual enrollment process. (This only applies to suppliers that complete the Forms CMS-855B, CMS-855I and CMS-855S.)

3. CMS Standard Electronic Data Interchange (EDI) Enrollment Form

See CMS Publication 100-04, Medicare Claims Processing Manual, chapter 24, sections 30 - 30.5 for further information.

4. State-Specific Forms for Certified Providers/Certified Suppliers

If the applicant is a certified supplier or certified provider, it will need to contact the state agency for any state-specific forms and to begin preparations for a state survey. (This does not apply to those certified entities, such as federally qualified health centers, that do not receive a state survey.)

10.2 – Provider and Supplier Types/Services

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The contractor shall consult other Medicare manuals for more information on how these providers and suppliers bill Medicare, their conditions of coverage, their conditions of participation, etc.

Provider and supplier specialty codes can be found at CMS Publication 100-04, chapter 26, sections 10.8 through 10.8.3.

10.2.1 – Certified Providers and Certified Suppliers That Enroll Via the Form CMS-855A

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A. Community Mental Health Centers

1. General Background Information

A community mental health center (CMHC) is a facility that provides mental health services. A CMHC must perform certain “**core services.**” These are:

- a. **Outpatient services** (This includes services for (1) children, (2) the elderly, (3) persons who are chronically mentally ill, and (4) certain persons who have been discharged from a mental health facility for inpatient treatment.)
- b. **24-hour**-a-day emergency psychiatric services;
- c. **Day treatment** or other **partial hospitalization (PH) services**, or psychosocial rehabilitation services; and
- d. **Screening** for patients being considered for admission to state mental health facilities.

NOTE: Partial hospitalization is the only core service for which a CMHC can bill Medicare as a CMHC. Thus, while a facility must furnish certain “core” services in order to qualify as a CMHC, it can only get reimbursed for one of them – partial hospitalization. However, the facility may still be able to enroll in Medicare as a Part B clinic if it does not perform partial hospitalization services.

In some instances, these core services can be furnished under arrangement. This generally means that the facility can arrange for another facility to perform the service if, among other things, CMS determines that the following conditions are met:

- The CMHC arranging for the particular service is authorized by State law to perform the service itself;
- The arranging CMHC accepts full legal responsibility for the service; and
- There is a written agreement between the two entities.

While the CMHC generally has the option to furnish services under arrangement, there is actually an instance where the facility must do so. If the CMHC is located in a State that

prohibits CMHCs from furnishing screening services (service (d) above), it must contract with another entity to have the latter perform the services. Any such arrangement must be approved by the CMS Survey & Operations Group (SOG) Locations (formerly CMS Regional Offices and hereafter referenced as “SOG Locations.”) (See CMS Publication (Pub.) 100-07, State Operations Manual, chapter 2, section 2250 for additional information on core services and arrangements.)

A CMHC must provide mental health services principally to individuals who reside in a defined geographic area (service area); that is, it must service a distinct and definable community.

2. Initial Enrollment and Certification

a. CMHC Conditions of Participation: Federal Regulations That Apply Beginning October 29, 2014

As of October 29, 2014, CMHCs are required to meet the conditions of participation outlined in 42 CFR Part 485, subpart J. CMHCs, like many other types of certified providers and certified suppliers, are therefore required to undergo a state survey as part of the certification and enrollment process. The SOG Location no longer performs the site visit nor does the CMHC need to submit the previously-required attestation statement. Except as otherwise noted in this chapter 10 or in another CMS directive, CMHC initial applications shall – on and after October 29, 2014 - be processed in the same manner as those for all other certified providers.

b. Site Visit - Initials Post Tie-In

The contractor shall order a site visit of the CMHC through the Provider Enrollment, Chain and Ownership System (PECOS) after the contractor receives the tie-in notice (or approval letter) from the SOG Location but before the contractor conveys Medicare billing privileges to the CMHC. This is to ensure that the provider is still in compliance with CMS’s enrollment requirements. The scope of the site visit will be consistent with sections 10.6.20(A) and 10.6.20(B) of this chapter; the National Site Visit Contractor (NSVC) will perform the site visit. The contractor shall not convey Medicare billing privileges to the provider prior to the completion of the NSVC’s site visit and the contractor’s review of the results.

i. Practice Locations

Each CMHC location must separately and independently meet the CMHC conditions of participation in 42 CFR Part 485, subpart J. Accordingly, a CMHC must separately enroll each of its practice locations. It cannot have multiple locations on a single application.

If a CMHC is changing its physical location, the contractor shall order a site visit of the new/changed location through PECOS after the contractor receives notice of approval from the SOG Location but before it switches the provider’s enrollment record to “Approved.” 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 sections 10.6.20(A) and 10.6.20(B) of this chapter. The NSVC will perform the site visit. The contractor shall not switch the provider’s enrollment record to “Approved” prior to the completion of the NSVC’s site visit and the contractor’s review of the results.

ii. Revalidation Site Visits

If the CMHC submits a Form CMS-855A revalidation application, the contractor shall order a site visit through PECOS. This is to ensure that the provider is still in compliance with CMS's enrollment requirements. The scope of the site visit will be consistent with section 10.6.20 of this chapter. The NSVC will perform the site visit. The contractor shall not make a final decision regarding the revalidation application prior to the completion of the NSVC's site visit and the contractor's review of the results.

3. CMHC 40 Percent Rule

a. Background

Effective October 29, 2014, under § 485.918(b)(1) a CMHC must provide at least 40 percent of its items and services to individuals who are not eligible for benefits under title XVIII of the Social Security Act; this is measured by the total number of CMHC clients treated by the CMHC for whom services are not paid for by Medicare, divided by the total number of clients treated by the CMHC in the applicable timeframe.

Pursuant to this requirement, a CMHC is required to submit to CMS a certification statement provided by an independent entity (such as an accounting technician). The document must certify that the entity has reviewed the CMHC's client care data for:

- Initial enrollments: The CMHC meets the 40 percent requirement for the prior 3 months.
- Revalidations: The CMHC meets the 40 percent requirement for each of the intervening 12-month periods between initial enrollment and revalidation.

The statement must be submitted as part of any initial enrollment or revalidation (including off-cycle revalidations).

When processing the application, the contractor shall abide by the following:

i. Contractor Does Not Receive the Certification

If the contractor does not receive the certification with the Form CMS-855, the contractor shall develop for the certification as it would with any other form of required supporting documentation. If the CMHC fails to submit the certification within the applicable time period, the contractor shall follow the instructions in section 10.4(H)(2) of this chapter.

ii. Contractor Receives the Certification

If the contractor receives the certification with the Form CMS-855 or timely receives the certification as part of a development request, the contractor shall review the certification to ensure that it complies with § 485.918(b)(1) and the provisions of this section 10.2.1(A). If the certification is compliant, the contractor shall continue processing the application; if the certification is not compliant, the contractor shall deny the application or, if it chooses, develop for a revised certification.

Sections 10.2.1(A)(3)(a)(i) and (ii) above do not apply if the contractor determines that the Form CMS-855 can be returned under section 10.4(H)(1) of this chapter.

If the contractor exceeds applicable timeliness standards due to the instructions in this section 10.2.1(A), the contractor shall accordingly document the provider file consistent with section 10.6.19(H) of this chapter.

iii. Special Guidelines

The following additional guidelines concerning certification apply:

- (1) As previously indicated, an appropriate official of the certifying entity must sign the document. (Notarization is not required unless CMS requests it.) Such persons may include accounting technicians, CEOs, officers, directors, etc.
- (2) The certification should be on the certifying entity's letterhead or should otherwise indicate that the document is clearly from the entity.
- (3) The contractor shall include the certification in the recommendation package it sends to the state agency.

Unless CMS instructs the contractor otherwise, the appropriate denial bases for failing to comply with § 485.918(b)(1) are §§ 424.530(a)(1) and 485.918(b)(1). The appropriate revocation bases are §§ 424.535(a)(1) and 485.918(b)(1). In cases involving the latter, CMS will determine the appropriate re-enrollment bar length under § 424.535(c) and will notify the contractor thereof.

4. For more information on CMHCs, refer to:

- Section 1861(ff) of the Social Security Act
- 42 CFR §§ 410.2, 410.43, and 410.110
- Pub. 100-07, chapter 2, sections 2250 - 2251F

B. Comprehensive Outpatient Rehabilitation Facilities (CORFs)

1. General Background Information

A CORF is a facility established and operated at a single fixed location exclusively for the purpose of providing diagnostic, therapeutic, and restorative services to outpatients by or under the supervision of a physician. Specific examples of such services include:

- Physician services (*)
- Physical therapy (*)
- Occupational therapy
- Respiratory therapy
- Speech pathology
- Social work or psychological services (*)
- Prosthetic/orthotic devices
- Lab services (must meet 42 CFR Part 493 requirements)

(* Services that the CORF must provide)

In addition:

- If the SOG Location determines that sufficient functional and operational independence exists, a CORF may be able to share space with another Medicare provider. However, the CORF may not operate in the same space at the same time with another Medicare provider. (See Pub. 100-07, chapter 2, sections 2364 - 2364C for more information.)
- Like most certified providers, CORFs must be surveyed by the state agency and must sign a provider agreement.
- On occasion, an outpatient physical therapy/speech language pathology location might convert to a CORF; prior to enrolling in Medicare, however, it must be surveyed to ensure that the CORF conditions of participation are met.

2. Enrollment Information

a. Offsite Locations

Notwithstanding the “single fixed location” language cited in subsection (B)(1) above, there may be isolated cases where the SOG Location permits a CORF to have an offsite location. This typically arises if the CORF wants to provide physical therapy, occupational therapy, or speech language pathology services away from the primary location. (This is permitted under 42 CFR § 485.58(e)(2)). The offsite location would not necessarily be separately surveyed but would be listed as a practice location on the CORF’s Form CMS-855A application.

b. Site Visits

i. Initial application – If a CORF submits an initial application, the contractor shall order a site visit through PECOS after the contractor receives the tie-in notice (or approval letter) from the SOG Location but before the contractor conveys Medicare billing privileges to the CORF. This is to ensure that the provider is still in compliance with CMS’s enrollment requirements. The scope of the site visit will be consistent with sections 10.6.20(A) and 10.6.20(B) of this chapter. The NSVC will perform the site visit. The contractor shall not convey Medicare billing privileges to the provider prior to the completion of the NSVC’s site visit and the contractor’s review of the results.

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

iii. New/changed location - If a CORF 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 after the contractor receives notice of approval from the RO but before the contractor switches the provider’s enrollment record to “Approved.” 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 sections 10.6.20(A) and 10.6.20(B) of this chapter. The NSVC will perform the site visit. The contractor shall not make a final decision regarding the change of information application prior to the completion of the NSVC’s site visit and the contractor’s review of the results.

3. Additional Information

For more information on CORFs, refer to:

- Section 1861(cc) of the Social Security Act
- 42 CFR Part 485, Subpart B
- Pub. 100-07, chapter 2
- Pub. 100-07, Appendix K
- Pub. 100-02, Benefit Policy Manual, chapter 12

C. End-Stage Renal Disease Facilities (ESRDs)

1. General Background Information

ESRD facilities are entities that provide renal services and related care for patients with irreversible and permanent kidney failure. As ESRD facilities are technically “suppliers,” they sign a supplier agreement rather than a provider agreement. Even if the ESRD facility is a hospital unit, it signs an agreement that is separate and distinct from the hospital’s agreement. ESRD entities/facilities cannot be mobile.

The provider-based rules for ESRD facilities are outlined in 42 CFR § 413.174 and are slightly different than those in the main provider-based regulation (42 CFR § 413.65). (For instance, § 413.174 uses the term “hospital-based” as opposed to “provider-based.”)

The ESRD Network is a group of organizations under contract with CMS that serve as liaisons between the agency and ESRD providers. The organizations oversee the care that ESRD patients receive, collect data, and furnish technical assistance to ESRD providers and patients.

2. Types of ESRD Facilities

Pub. 100-07, chapter 2, section 2272 lists several classifications of ESRD facilities. They are summarized as follows:

i. Hospital-Based ESRD Facility

A hospital-based ESRD facility is a separately certified ESRD facility that (1) is an outpatient department of a hospital and (2) meets the ESRD conditions of coverage at 42 CFR Part 494. A hospital-based ESRD facility is owned and administered by a hospital or critical access hospital and is physically located on the hospital campus. If a hospital operates multiple separately certified hospital-based ESRD facilities, each separate ESRD facility must have its own CMS certification number (CCN) and be separately enrolled.

A hospital-based ESRD facility is discussed at 42 CFR § 413.174(c) and meets the criteria listed therein (e.g., ESRD facility and hospital have a common governing body and are financially integrated). Hospital-based ESRD facilities are assigned CCNs from the 2300-2499 series.

ii. Satellite Renal Dialysis Facility (Hospital-Based)

A satellite renal dialysis facility is a hospital-owned and hospital-administered ESRD facility but is not located on the campus of the hospital. A single hospital may have several satellite renal dialysis facilities. Each satellite facility: (1) is separately certified and surveyed; (2) must

independently meet the ESRD conditions of coverage; (3) is assigned its own CCN; and (4) be separately enrolled. Satellite renal dialysis facilities (hospital-based) are assigned CCNs in the 3500-3699 series.

iii. Independent Renal Dialysis Facility

An independent renal dialysis facility is any ESRD facility that does not meet the definition of a hospital-based renal dialysis facility or satellite renal dialysis facility as described in the paragraphs above. An independent renal dialysis facility may be physically located on a hospital campus, but it is not owned and/or administered by the hospital. Independent renal dialysis facilities are assigned CCNs in the 2500-2899 series and are individually enrolled.

iv. Special Purpose Renal Dialysis Facility (SPRDF) (§ 494.120)

This type of renal disease facility is temporarily certified to furnish dialysis at special locations on a short-term basis (i.e., up to 8 months in any 12 month period) to a group of dialysis patients who would otherwise be unable to obtain treatment in the geographical area. The SOG Location must clearly specify the limited nature of the SPRDF certification, the time period covered by the certification, and the automatic termination of payment on the last day of the certification period in its notifications. The special locations for SPRDF fall into two categories:

(A) Vacation Camps - Vacation camps serve dialysis patients temporarily residing there. A vacation camp SPRDF would allow campers to receive hemodialysis at the camp site, avoiding interruption of the camping experience. Vacation camps may be approved for the duration of the camp but up to a maximum of 8 months in any 12-month period.

(B) Emergency Circumstance SPRDFs - These locations are set up to provide dialysis services to those ESRD patients who would otherwise be unable to obtain such services in their geographical area as a result of a natural or man-made disaster or a need for a greater capacity to dialyze patients who may have been evacuated from another location. The CMS SOG Location may extend the time period in emergency SPRDF approvals, where necessary, beyond the standard eight-month period based upon the termination of the emergency condition.

SPRDFs are assigned CCNs in the 3700-3799 series when owned and administered by a hospital and in the 2900-2999 series for independent facilities; they are individually enrolled.

3. ESRD Enrollment

An ESRD facility is separately and individually certified and does not have any branch, multiple, or parent locations. As such, each type of ESRD facility/location must independently and separately enroll as such via the Form CMS-855A; multiple sites cannot be listed on a single application.

The Form CMS-855A does not distinguish between the different types of ESRD facilities. If an enrolled ESRD facility wants to change to another type of ESRD facility or expand/add ESRD stations, the provider therefore need not submit a Form CMS-855A change of information (e.g., an ESRD station does not qualify as a practice location on the Form CMS-855A). However, the SOG Location may issue a tie-in notice or approval letter to the contractor as notification of the change. Also, the ESRD facility shall contact the state and the SOG Location to see if it must submit other documents or undergo other reviews pursuant to the change in ESRD type.

4. ESRD Survey and Certification

The standard CMS survey and certification form used for ESRDs is the Form CMS-3427. For more information on this form, see Pub. 100-07, chapter 2, section 2247B.

5. Site Visits

Site visits for ESRDs are performed during the survey and certification process by the state agency.

6. For further information on ESRD facilities, refer to:

- Section § 1881 of the Social Security Act
- 42 CFR Part 405, Subpart U
- Pub. 100-07, chapter 2, section 2270 – 2287B
- Pub. 100-02, chapter 11
- Pub. 100-04, Claims Processing Manual, chapter 8

D. Federally Qualified Health Centers (FQHCs)

1. Statutory Background

Section 4161(a)(2) of OBRA '90 (P.L. 101-508) amended §1861(aa) of the Act and established FQHC services as a benefit under the Medicare program effective October 1, 1991. The statutory requirements that entities must meet to be considered an FQHC for Medicare purposes are at §1861(aa)(4) of the Act. Regulations establishing the FQHC benefit and outlining the Conditions for Coverage for FQHCs were published on June 12, 1992, in the Federal Register (57 FR 24961) and became effective on the date of publication. These regulations were amended on April 3, 1996 (61 FR 14640). Section 13556 of OBRA 1993 (P.L. 103-66) amended §1861(aa) of the Act by adding outpatient health programs or facilities operated by a tribe or tribal organization under the Indian Self-Determination Act or by an urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act, as entities eligible to participate in Medicare as FQHCs.

2. Requirements

FQHCs furnish services such as those performed by physicians, nurse practitioners, physician assistants, clinical psychologists, certified nurse-midwives, and clinical social workers. This also includes certain preventive services like prenatal services, immunizations, blood pressure checks, hearing screenings and cholesterol screenings. (See Pub. 100-02, chapter 13 for more information). To participate in the Medicare program, applicants seeking initial enrollment as an FQHC must submit a Form CMS-855A application to the appropriate Medicare Administrative Contractor (MAC). Even though they complete the Form CMS-855A application, FQHCs are considered Part B certified suppliers and are paid Part B benefits for FQHC services.

FQHCs are not required to obtain a state survey. However, FQHCs still must meet all applicable state and local requirements and submit all applicable licenses. Typically, the Health Resources

and Services Administration (HRSA) will verify such state/local compliance by asking the FQHC to attest that it meets all state/local laws.

FQHCs can be located in a rural or urban area that is designated as either a health professional shortage area or an area that has a medically underserved population.

For purposes of Medicare enrollment, an FQHC is defined as an entity that has entered into an agreement with CMS to meet Medicare program requirements under 42 CFR § 405.2434(a), and (as outlined in Pub. 100-07, chapter 9, exhibit 179):

- Is receiving a grant under § 330 of the Public Health Service (PHS) Act;
- Is receiving funding under a contract with the recipient of a § 330 grant, and meets the requirements to receive a grant under § 330 of the PHS Act;
- Is an FQHC “Look-Alike” (i.e., HRSA), has notified it that it meets the requirements for receiving a § 330 grant, even though it is not actually receiving such a grant);
- Was treated by CMS as a comprehensive federally funded health center as of January 1, 1990; or
- Is an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act or by an Urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act.

3. Initial FQHC Applications

i. Contractor Review and Required Documents

In contrast to both past practice and the process that is normally followed with other certified provider/certified supplier types, the contractor does not make a recommendation for approval to the state/SOG Location for FQHC applications. Instead, the contractor will either approve or deny the application at the contractor level pursuant to the instructions in this section.

The following documents must be included with the FQHC’s completed Form CMS-855A application:

- One signed and dated copy of the attestation statement (Exhibit 177). In order to attest to being in compliance, the facility must be open and operating when the attestation is signed. Since FQHCs must sign an agreement stipulating that they will comply with § 1861(aa)(4) of the Act and specific FQHC regulations, this statement serves as the Medicare FQHC benefit (or provider/supplier) agreement when it is also signed and dated by PEOG. (See Pub. 100-07, chapter 2, section 2826B.)
- HRSA Notice of Grant Award or FQHC Look-Alike Designation that includes an address for the site of the applicant which matches the practice location reported on the Form CMS-855A. A Notice of Grant Award by HRSA verifies that the applicant qualifies as a FQHC grant recipient; the FQHC Look-Alike Designation Memo from HRSA verifies look-alike status.
- Form CMS-588; Electronic Funds Transfer (EFT) Authorization Agreement.
- Clinical Laboratory Improvement Act (CLIA) Certificate (if applicable). Facilities that examine human specimens for the diagnosis, prevention, or treatment of any disease or impairment of, or the assessment of the health of, human beings is considered a laboratory and must meet CLIA requirements. These facilities must apply and obtain a certificate from the

CLIA program that corresponds to the complexity of tests performed. Certain types of laboratories and laboratory tests are NOT subject to meeting CLIA requirements. One example would be facilities which serve only as collection stations. A collection station receives specimens to be forwarded to a laboratory performing diagnostics test. Pub. 100-07, chapter 6, section 6002 provides additional details regarding laboratories and laboratory tests NOT subject to CLIA requirements. It is the FQHC's responsibility to review the CLIA requirements and obtain a CLIA certificate if needed. Neither the contractor nor CMS determines whether the FQHC needs to obtain and submit a CLIA certificate.

- Copy of state license (if applicable).

ii. General Processing Concepts

(A) Practice Locations - An FQHC cannot have multiple sites or practice locations. Each location must be separately enrolled and will receive its own CCN.

(B) Name on Exhibit 177 - The contractor shall ensure that Exhibit 177 contains the same legal business name and address as that which the FQHC provided in Section 2 and Section 4, respectively, of the Form CMS-855A. If the attestation contains a different name, the contractor shall develop for the correct name.

(C) Date on Exhibit 177 - The contractor shall ensure that the date on which the Exhibit 177 was signed is on or after the date the FQHC listed as its effective date on the Form CMS-855A application. If the Exhibit 177 was signed prior to the listed effective date, the contractor shall follow the instructions in section (D)(5)(b) below; the FQHC should be providing services in order to meet the regulations noted in Exhibit 177.

(D) Date Application Complete - When reviewing an initial FQHC application, the contractor shall verify the date on which the FQHC's application was complete. To illustrate, assume that the FQHC submitted an initial application on March 1. Two data elements were missing, so the contractor requested additional information. The two elements were submitted on March 30. The contractor shall therefore indicate the March 30 date in its approval letter as the effective date of the FQHC.

(E) Site Visits - Site visits for FQHCs are performed by HRSA prior to enrollment.

(F) Contractor Jurisdiction - Except for tribal and Urban Indian FQHCs, a freestanding FQHC that is initially enrolling is assigned to the Medicare Administrative Contractor (MAC) that covers the state in which the FQHC is located. An initially enrolling tribal or Urban Indian FQHC is assigned to the Jurisdiction H MAC.

(G) Tribal/Urban Indian Organizations – Certain outpatient health programs or facilities may be operated by a tribe or tribal organization or by an Urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act. The contractor shall confirm the applicant's attestation and tribal/urban Indian status if the FQHC indicates on the application that it has such status; several means are available:

- The applicable Indian Health Service (IHS) web link at <https://www.ihs.gov/locations/>. The contractor can search for the facility by clicking on the "Find Health Care" sub-link <https://www.ihs.gov/findhealthcare/?CFID=15011511&CFTOKEN=36378825> or downloading the Excel complete listing of HIS facilities. (These are the highly recommended means of verification.)

- Contacting (1) the IHS directly, (2) contacting the applicable SOG Location, or (3) the contractor's PEOG BFL.

(H) Potential RHC Relationship – On occasion, a rural health clinic (RHC) may seek to convert to an FQHC. (A facility cannot be both an RHC and an FQHC.) Accordingly, in its review of an initial FQHC application, the contractor shall check PECOS to determine whether an RHC is enrolled at the same location. If one is, the contractor shall refer the matter to MedicareProviderEnrollment@cms.hhs.gov. In doing so, the contractor shall furnish to PEOG (1) the names, NPIs, and shared address of the RHC and FQHC, and (2) a copy of all information submitted with the FQHC application; the e-mail's subject line shall state: "RHC & FQHC shared address".

4. Initial FQHC Applications - Determination

a. Approval

The contractor shall contact PEOG via email at MedicareProviderEnrollment@cms.hhs.gov if it believes that the FQHC's initial application should be approved. The contractor shall provide to PEOG: (1) a copy of the draft approval letter (see section 10.7.19 of this chapter for a model FQHC approval letter); (2) the Form CMS-855A application or PECOS Application Data Report (ADR) and all supporting documentation; (3) a copy of the FQHC's HRSA documentation; and (4) Exhibit 177.

While awaiting PEOG's final determination---and beginning on the date following the sending of the aforementioned e-mail---the application processing time clock is stopped. It resumes on the date on which the contractor receives PEOG's decision. Communication between the contractor and PEOG during this "waiting period" (e.g., PEOG request for additional information from the contractor) does not restart the clock.

b. Denial

If the contractor believes that the FQHC's application should be denied, the contractor shall: (1) notify the applicant of the denial using the appropriate model letter guidance in section 10.7.8 of this chapter; and (2) copy the SOG Location and, as applicable, HRSA's Bureau of Primary Health Care or the Indian Health Service on the letter consistent with the instructions in this chapter. If the contractor is uncertain as to whether a denial is warranted or what the appropriate denial ground under 42 CFR 424.530(a) should be, it may contact its PEOG BFL for guidance.

5. Post-PEOG Review and Response to Contractor

If PEOG determines (based on the information the contractor furnished) that the FQHC's application should be approved, PEOG will:

- Assign the CCN, which will be part of the 1800-1989 series
- Assign the effective date, which will be the date the FQHC application was considered complete by the contractor
- Make any necessary revisions to the draft approval letter

- Sign and date the attestation using the completion date, which is also the effective date (Exhibit 177)
- E-mail all of the foregoing documents and data to the contractor, at which point the aforementioned processing time clock resumes.

6. Post-Approval Contractor Action

If PEOG notifies the contractor that the FQHC's application should be approved, the contractor shall send the approval letter to the FQHC with a copy of the signed Exhibit 177. (The contractor shall also (1) copy the appropriate SOG Location and HRSA's Bureau of Primary Health Care or the Indian Health Service (as applicable) on the letter via mail, e-mail, or fax; and (2) send a copy of the signed Exhibit 177 to the appropriate SOG Location via any of the foregoing three means.)

7. Location Changes

i. Verification

If an FQHC is changing the physical location of an existing site, the FQHC must submit the following documentation (as applicable to that FQHC) to the contractor:

- For § 330 grantees, a Notice of Grant Award approving the physical location change and the new address; or
- For look-alikes, an updated letter from HRSA approving the physical location change and listing the new address.

(Consistent with the instructions in this chapter, the contractor shall develop for this documentation with the FQHC if the latter fails to submit it.)

For tribal/Urban Indian organizations, the contractor may confirm the new location via the IHS website or by contacting IHS. (See section (D)(3)(ii)(G) above for the web link.)

In all cases, the new address listed on the notice of grant award, IHS website, etc., must match that listed on the Form CMS-855A change request. If it does not, the contractor shall develop with the FQHC for clarification consistent with the instructions in this chapter.

ii. Approval

If approving the location change, the contractor does not issue a recommendation of approval to the SOG Location, notwithstanding any instruction to the contrary in this chapter; rather, the contractor shall approve the location change in PECOS and issue an approval letter to the FQHC. The contractor shall send the SOG Location a copy of the approval letter of the change via e-mail. Beginning on March 15, 2021, tie-in notices will not be issued for address changes.

iii. Denial

If the contractor does not approve the location change (i.e., the FQHC is no longer located in a shortage area, the FQHC fails to submit the applicable HRSA supporting documentation after contractor development (discussed above), or another reason is implicated), the contractor shall refer the matter to PEOG at ProviderEnrollmentRevocations@cms.hhs.gov consistent with all

applicable instructions in this chapter and other CMS directives. (The referral shall include, at a minimum, the FQHC's LBN and NPI as well as a brief explanation of the situation and the reason for referral.) PEOG will review the matter and instruct the contractor on how to proceed.

While awaiting PEOG's final determination---and beginning on the date following the sending of the aforementioned e-mail---the application processing time clock is stopped. It resumes on the date on which the contractor receives PEOG's decision. Communication between the contractor and PEOG during this "waiting period" (e.g., PEOG request for additional information from the contractor) does not restart the clock.

8. Revocations and Other Transactions

Except as otherwise stated or required by CMS, the contractor shall continue to adhere to the applicable instructions in this chapter and all other CMS directives regarding:

- Potential FQHC revocations and referrals (including sending the referral/information to the appropriate PEOG mailbox)
- Changes of ownership
- Changes of information
- Revalidations
- Reactivations

9. Complaint Investigations

CMS SOG Locations investigate complaints that raise credible allegations of an FQHC's noncompliance with health and safety standards found at 42 CFR 405 Subpart X, and 42 CFR 491 Subpart A (except for 42 CFR § 491.3). The contractor shall refer such complaints to the SOG Location that has jurisdiction over the FQHC.

10. For additional general information on FQHCs, refer to:

- Section 1861(aa)(3-4) of the Social Security Act
- 42 CFR Part 491 and 42 CFR Part 405, subpart X
- Pub. 100-07, chapter 2, sections 2825 – 2826H
- Pub. 100-07, chapter 9, exhibits 177 and 179
- Admin Info 21 06-ALL – Transitioning FQHC Certification Enrollment Performed by the CMS SOG (Standard Operating Procedures attached)
- Pub. 100-04, chapter 9
- Pub. 100-02, chapter 13

For additional information on the appropriate contractor jurisdictions for incoming FQHC enrollment applications, see Pub. 100-04, chapter 1, section 20 as well as Pub. 100-07, chapter 9, exhibit 179.

E. Histocompatibility Laboratories

1. General Background Information

A histocompatibility laboratory does "matching" tests in preparation for procedures such as kidney transplants, bone marrow transplants, and blood platelet transfusions. It is the only type of laboratory that must submit a Form CMS-855A application. Each histocompatibility lab must

meet all applicable requirements in 42 CFR Part 493 (see 42 CFR § 493.1 in particular) and undergo a state survey.

2. Additional Information

For information on the appropriate contractor jurisdiction for incoming histocompatibility lab applications, see Pub. 100-04, chapter 1, section 20.

F. Home Health Agencies (HHAs)

1. General Background Information

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

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

2. Site Visit Requirements

See sections 10.6.20(A) and 10.6.20(B) of this chapter for more information on HHA site visit requirements.

3. HHA Components

There are two potential “components” of an HHA organization:

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

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

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

4. Out-of-State HHA Operations

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

- It must be certified by the state in which its CCN is based.
- The involved states must have a written reciprocal agreement permitting the HHA to provide services in this manner. In those states that have a reciprocal agreement, HHAs are not

required to be separately approved in each state; consequently, they would not have to obtain a separate Medicare provider agreement/number in each state. HHAs residing in a state that does not have a written reciprocal survey agreement with a contiguous state are precluded from providing services across state lines; the HHA must establish a separate parent agency in the state in which it wishes to provide services.

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

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

5. Verification of HHA Sites

HHAs are not permitted to share a practice location address. If the contractor receives an application from an HHA that has the same general practice location address as another enrolled (or enrolling) HHA and the contractor has reason to suspect that the HHAs may be concurrently operating out of the same suite or office, the contractor shall notify the NSVC of this at the time the contractor orders the required site visit through PECOS. If the site visit uncovers two HHAs operating within the same practice location address, the contractor shall deny/reject the application for enrollment.

6. Nursing Registries

If the HHA checks “yes” in Section 12B of the Form CMS-855A, the contractor shall ensure that the information furnished about the HHA nursing registry is accurate. (A nursing registry is akin to a staffing agency, whereby a private company furnishes nursing personnel to hospitals, clinics, and other medical providers.)

7. HHA Ownership Changes

a. Background

Effective January 1, 2011, and in accordance with 42 CFR § 424.550(b)(1), if there is a change in majority ownership of an HHA by sale (including asset sales, stock transfers, mergers, and consolidations) within 36 months after the effective date of the HHA’s initial enrollment in Medicare or within 36 months after the HHA’s most recent change in majority ownership, the provider agreement and Medicare billing privileges do not convey to the new owner. The prospective provider/owner of the HHA must instead:

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

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

effect of asset sales, stock transfers, consolidations, or mergers during the 36-month period after Medicare billing privileges are conveyed or the 36-month period following the HHA's most recent change in majority ownership.

b. Exceptions

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

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

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

c. Timing of 36-Month Period

As indicated earlier, the provisions of 42 CFR § 424.550(b)(1) and (2) (as enacted in “CMS-6010-F, Medicare Program; Home Health Prospective Payment System Rate Update for Calendar Year 2011; Changes in Certification Requirements for Home Health Agencies and Hospices; Final Rule”) became effective January 1, 2011. This means these provisions impact only those HHA ownership transactions whose effective date is on or after January 1, 2011. However, the provisions can apply irrespective of when the HHA first enrolled in Medicare. Consider the following illustrations:

- Example 1 – Smith HHA initially enrolled in Medicare effective July 1, 2009. Smith underwent a change in majority ownership effective September 1, 2011. The provisions of § 424.550(b)(1) applied to Smith because it underwent a change in majority ownership within 36 months of its initial enrollment.
- Example 2 – Jones HHA initially enrolled in Medicare effective July 1, 2007. Jones underwent a change in majority ownership effective February 1, 2019. Section 424.550(b)(1) did not apply to this transaction because it occurred more than 36 months after Jones's initial enrollment. Suppose, however, that Jones underwent another change in majority ownership effective February 1, 2020. Section 424.550(b)(1) applied to this transaction because it took place within 36 months after Jones's most recent change in majority ownership (i.e., on February 1, 2019).
- Example 3 – Davis HHA initially enrolled in Medicare effective July 1, 2012. It underwent its first change in majority ownership effective December 1, 2015. This change was not affected by § 424.550(b)(1) because it occurred more than 36 months after Davis's initial enrollment. Davis underwent another change in majority ownership effective July 1, 2019. This change, too, was unaffected by § 424.550(b)(1), for it occurred more than 36 months after the

HHA's most recent change in majority ownership (i.e., on December 1, 2015). Davis underwent another majority ownership change on July 1, 2020. This change was impacted by § 424.550(b)(1), since it occurred within 36 months of the HHA's most recent change in majority ownership (i.e., on July 1, 2019).

d. Determining the 36-Month Rule's Applicability

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

Step 1 – Change in Majority Ownership

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

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

Assumption of a greater than 50 percent direct ownership interest can generally occur in one of three ways. First, an outside party that is currently not an owner can purchase more than 50 percent of the business in a single transaction. Second, an existing owner can purchase an additional interest that brings its total ownership stake in the business to greater than 50 percent. For instance, if a 40 percent owner purchased an additional 15 percent share of the HHA, this would constitute a change in majority ownership. This is consistent with the verbiage in the aforementioned definition of "change in majority ownership" regarding the "cumulative effect" of asset sales, transfers, etc. Another example of a change in majority ownership would be if a 50 percent owner obtains any additional amount of ownership (regardless of the percentage) and hence becomes a majority owner; thus, for instance, if a 50 percent owner were to acquire an additional .001 percent ownership stake, he or she becomes a majority owner and the transaction involves a change in majority ownership.

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

Step 2 – 36-Month Period

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

If the effective date of the transfer does not fall within either of the aforementioned 36-month periods, the contractor may process the application normally; specifically, the contractor shall, as

applicable and depending upon the facts of the case, process the application as a change of information under 42 CFR § 424.516(e) or as a potential change of ownership under 42 CFR § 489.18.

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

Step 3 – Applicability of Exceptions

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

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

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

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

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

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

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

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

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

e. Determination

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

If no exception applies, the contractor shall refer the case to its PEOG BFL for review. Under no circumstances shall the contractor apply the 36-month rule to the HHA and require an initial enrollment based thereon without the prior approval of PEOG. If PEOG agrees with the contractor's determination, the contractor shall send a letter to the HHA notifying it that, as a result of § 424.550(b)(1), the HHA must:

- Enroll as an initial applicant; and

- Obtain a new state survey or accreditation survey after it has submitted its initial enrollment application and the contractor has made a recommendation for approval to the state/SOG Location.

As the new owner must enroll as a new provider, the contractor shall also deactivate the HHA's billing privileges if the sale has already occurred. The effective date of the deactivation shall be the date the HHA is notified that it must enroll as an initial applicant. If the sale has not occurred, the contractor shall alert the HHA that it must submit a Form CMS-855A voluntary termination application.

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

f. Additional Notes

The contractor is advised of the following:

- i. If the contractor learns of an HHA ownership change by means other than the submission of a Form CMS-855A application, it shall notify its PEOG BFL immediately.
- ii. If the contractor determines, under Step 3 above, that one of the § 424.550(b)(2) exceptions applies, the ownership transfer still qualifies as a change in majority ownership for purposes of the 36-month clock. To illustrate, assume that an HHA initially enrolled in Medicare effective July 1, 2010. It underwent a change in majority ownership effective February 1, 2012. The contractor determined that the transaction was exempt from § 424.550(b)(1) because the HHA submitted full cost reports in the previous 2 years. On February 1, 2014, the HHA underwent another change in majority ownership that did not qualify for an exception. The HHA thus had to enroll as a new HHA under § 424.550(b)(1) because the transaction occurred within 36 months of the HHA's most recent change in majority ownership - even though the February 2012 change was exempt from § 424.550(b)(1).

8. Capitalization

a. Background

Effective January 1, 2011, and pursuant to 42 CFR §§ 489.28(a) and 424.510(d)(9), an HHA entering the Medicare program - including a new HHA resulting from a change of ownership if the change of ownership results in a new provider number being issued - must have available sufficient funds (known as initial reserve operating funds) at (1) the time of application submission and (2) all times during the enrollment process, to operate the HHA for the three-month period after the Medicare contractor conveys billing privileges (exclusive of actual or projected accounts receivable from Medicare). This means that the HHA must also have available sufficient initial reserve operating funds during the 3-month period following the conveyance of Medicare billing privileges.

b. Points of Review

At a minimum, the contractor shall verify that the HHA meets the required amount of capitalization:

- Prior to making its recommendation for approval;
- After a recommendation for approval is made but before the SOG Location review process is completed;
- After the SOG Location review process is completed but before the contractor conveys Medicare billing privileges to the HHA; and
- During the 3-month period after the contractor conveys Medicare billing privileges to the HHA

For initial applications, the contractor shall verify that the HHA meets all of the capitalization requirements addressed in 42 CFR § 489.28. (Note that capitalization need not be reviewed for revalidation, reactivation applications, and changes of ownership that do not require a new/initial enrollment under § 424.550(b).) The contractor may request from the HHA any and all documentation deemed necessary to perform this task.

The HHA must submit proof of capitalization within 30 calendar days of the contractor's request to do so. Should the HHA fail to furnish said proof and billing privileges have not yet been conveyed, the contractor shall deny the HHA's application pursuant to § 424.530(a)(8)(i) or (ii), as applicable. If billing privileges have been conveyed, the contractor shall revoke the HHA's billing privileges per § 424.535(a)(11).

Should the contractor deem it necessary to verify the HHA's level of capitalization more than once within a given period (e.g., more than once between the time a recommendation is made and the completion of the RO review process), the contractor shall seek approval from its PEOG BFL.

c. Determining Initial Reserve Operating Funds

Initial reserve operating funds are sufficient to meet the requirement of 42 CFR § 489.28(a) if the total amount of such funds is equal to or greater than the product of the actual average cost per visit of three or more similarly situated HHAs in their first year of operation (selected by CMS for comparative purposes) multiplied by the number of visits projected by the HHA for its first 3 months of operation--or 22.5 percent (one fourth of 90 percent) of the average number of visits reported by the comparison HHAs--whichever is greater.

The contractor shall determine the amount of the initial reserve operating funds by using reported cost and visit data from submitted cost reports for the first full year of operation from at least three HHAs that the contractor serves that are comparable to the HHA seeking to enter the Medicare program. Factors to be used in making this determination shall include:

- Geographic location and urban/rural status;
- Number of visits;
- Provider-based versus free-standing status; and
- Proprietary versus non-proprietary status.

The adequacy of the required initial reserve operating funds is based on the average cost per visit of the comparable HHAs, by dividing the sum of total reported costs of the HHAs in their first year of operation by the sum of the HHAs' total reported visits. The resulting average cost per visit is then multiplied by the projected visits for the first 3 months of operation of the HHA

seeking to enter the program, but not less than 90 percent of average visits for a 3-month period for the HHAs used in determining the average cost per visit.

d. Proof of Operating Funds

As described further in section 10.2.1(F)(8)(e) and (g) below, the HHA must provide CMS with adequate proof of the availability of initial reserve operating funds. In some cases, an HHA may have all or part of the initial reserve operating funds in cash equivalents. For purposes of the capitalization requirement, cash equivalents are short-term, highly liquid investments that are readily convertible to known amounts of cash and that present insignificant risk of changes in value. A cash equivalent that is not readily convertible to a known amount of cash as needed during the initial 3-month period for which the initial reserve operating funds are required does not qualify as meeting the initial reserve operating funds requirement. Examples of cash equivalents for purposes of the capitalization requirement are Treasury bills, commercial paper, and money market funds.

As with funds in a checking, savings, or other account, the HHA also must be able to document the availability of any cash equivalents. CMS may later require the HHA to furnish: (1) another attestation from the financial institution that the funds remain available; and/or (2) documentation from the HHA that any cash equivalents remain available until a date when the HHA will have been surveyed by the state agency or by an approved accrediting organization. The officer of the HHA who will be certifying the accuracy of the information on the HHA's cost report must certify what portion of the required initial reserve operating funds constitutes non-borrowed funds, including funds invested in the business by the owner. That amount must be at least 50 percent of the required initial reserve operating funds. The remainder of the reserve operating funds may be secured through borrowing or line of credit from an unrelated lender.

e. Borrowed Funds

i. General Information

If borrowed funds are not in the same account(s) as the HHA's own non-borrowed funds, the HHA also must provide proof that the borrowed funds are available for use in operating the HHA. As part of this, and except as stated in section 10.2.1(F)(8)(e)(ii) below, the HHA must (at a minimum) furnish: (1) a copy of the statement(s) of the HHA's savings, checking, or other account(s) containing the borrowed funds; and (2) an attestation from an officer of the bank or other financial institution that the funds are in the account(s) and are immediately available to the HHA. As with the HHA's own (that is, non-borrowed) funds, CMS later may require the HHA to establish the current availability of such borrowed funds; this could include furnishing an attestation from a financial institution or other source (as may be appropriate) to establish that such funds will remain available until a date when the HHA will have been surveyed by the state agency or by an approved accrediting organization.

ii. Inability to Obtain Attestation Statements

Several national bank chains are no longer providing attestation statements, which are necessary under 42 CFR § 489.28(d), to verify the existence of capitalization funds for HHAs.

Accordingly, the contractor may accept a current bank statement unaccompanied by an attestation from an officer of the bank or other financial institution if the HHA cannot secure the attestation. All efforts must be exhausted, however, to obtain the attestation of funds statement before the contractor can forgo this requirement. In no circumstances shall the MAC instruct the

HHA to obtain a different bank that will provide an attestation statement. All other documents listed in section 10.2.1(F)(8) must be obtained if required.

f. Line of Credit

If the HHA chooses to support the availability of a portion of the initial reserve operating funds with a line of credit, it must provide CMS with a letter of credit from the lender. CMS later may require the HHA to furnish an attestation from the lender that the HHA, upon its certification into the Medicare program, continues to be approved to borrow the amount specified in the letter of credit.

g. Documents

As part of ensuring the prospective HHA's compliance with the capitalization requirements, the contractor shall obtain the following from the HHA:

- A document outlining the HHA's projected budget – preferably, a full year's budget broken out by month
- A document outlining the number of anticipated visits - preferably a full year broken out by month
- An attestation statement from an officer of the HHA defining the source of funds
- Copies of bank statements, certificates of deposits, etc., supporting that cash is available (must be current)
- Except as stated in section 10.2.1(F)(8)(e)(ii) above, a letter from an officer of the bank attesting that funds are available
- If available, audited financial statements

The contractor shall also ensure that the capitalization information in Section 12 of the Form CMS-855A is provided.

9. Additional HHA Review Activities

As stated in section 10.2.1(F)(8) of this chapter, the contractor must verify that a newly enrolling HHA has the required amount of capitalization after the CMS RO review process is completed but before the contractor conveys Medicare billing privileges to the HHA. Accordingly, the HHA must submit proof of capitalization during this "post-SOG Location" period.

To confirm that the HHA is still in compliance with Medicare enrollment requirements prior to the issuance of a provider agreement and conveyance of Medicare billing privileges, the contractor during the post-SOG Location review period shall ensure that each entity and individual listed in sections 2, 5 and 6 of the HHA's Form CMS-855A application is again reviewed against the Medicare Exclusion Database (MED) and the System for Award Management (SAM) (formerly the General Services Administration (GSA) Access Management System). This activity applies: (1) regardless of whether the HHA is provider-based or freestanding; and (2) only to initial enrollments.

The capitalization and MED/SAM re-reviews described above shall be performed once the SOG Location notifies the contractor via e-mail that the SOG Location's review is complete. (Per sections 10.6.20(A) and 10.6.20(B) of this chapter, a site visit will be performed after the contractor receives the tie-in/approval notice from the SOG Location but before the contractor conveys Medicare billing privileges to the HHA.) If:

a. The HHA is still in compliance (e.g., no owners or managing employees are excluded/debarred; capitalization is met):

- i. The contractor shall notify the SOG Location of this via e-mail. The notice shall specify the date on which the contractor completed the aforementioned reviews.
- ii. The SOG Location will: (1) CCN; (2) sign a provider agreement; and (3) send a tie-in notice or approval letter to the contractor. Per section 10.6.1(B) of this chapter, the contractor shall complete its processing of the tie-in notice/approval letter within 45 calendar days of receipt (during which time a site visit will be performed).
- iii. Upon receipt of SOG Location's notification, the contractor will perform the capitalization reviews discussed in section 10.2.1(F)(8) and MED/SAM reviews discussed in section 10.2.1(F)(9) of this chapter.

b. The HHA is not in compliance (e.g., capitalization is not met):

- i. The contractor shall deny the application in accordance with the instructions in this chapter and issue appeal rights. (The denial date shall be the date on which the contractor completed its follow-up capitalization and MED/SAM reviews.)
- ii. Notify the SOG Location of the denial via e-mail. (PEOG, not the SOG Location, will handle any corrective action plan (CAP) or appeal related to the contractor's denial.)
- iii. Upon receipt of SOG Location's notification, the contractor will perform capitalization reviews discussed in section 10.2.1(F)(8) and MED/SAM reviews discussed in section 10.2.1(F)(9) of this chapter.

10. Recommendation Before New HHA Location Established

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

11. Additional Information

For more information on HHAs, refer to:

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

- Pub. 100-02, chapter 7

G. Hospices

1. General Background Information

A hospice is a public agency or private organization or subdivision of either of these that is primarily engaged in providing a comprehensive set of services such as the assessment and management of pain. Typically, the need for services is identified and coordinated by an interdisciplinary group to provide for the physical, psychosocial, spiritual, and emotional needs of a terminally ill patient and/or family members, as delineated in a specific patient plan of care.

2. Enrollment Information

a. Multiple Practice locations

Hospices are not precluded from having multiple practice locations if permitted by the SOG Location. If the SOG Location disapproves an additional practice location, the location must seek Medicare approval as a separate hospice with its own enrollment and provider agreement. (See Pub. 100-07, chapter 2, section 2088 for the policies regarding multiple hospice locations.)

b. Site Visits

i. Initial application – If a hospice submits an initial application, the contractor shall order a site visit through PECOS after the contractor receives the tie-in notice (or approval letter) from the SOG Location but before the contractor conveys Medicare billing privileges to the hospice. This is to ensure that the provider is still in compliance with CMS’s enrollment requirements. The scope of the site visit will be consistent with section 10.6.20(A) and 10.6.20(B) of this chapter. The NSVC will perform the site visit. The contractor shall not convey Medicare billing privileges to the provider prior to the completion of the NSVC’s site visit and the contractor’s review of the results.

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

iii. New/changed location - If a hospice 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 after the contractor receives notice of approval from the SOG Location but before the contractor switches the provider’s enrollment record to “Approved.” 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 sections 10.6.20(A) and 10.6.20(B) of this chapter. The NSVC will perform the site visit. The contractor shall not switch the provider’s enrollment record to “Approved” prior to the completion of the NSVC’s site visit and the contractor’s review of the results.

3. Additional Information:

For more information on hospices, refer to:

- Sections 1861(u) and 1861(dd) of the Social Security Act
- 42 CFR Part 418
- Pub. 100-07, chapter 2, sections 2080 – 2089
- Pub. 100-04, chapter 11
- Pub. 100-02, chapter 9

H. Hospitals and Hospital Units

1. General Background Information

Hospitals and hospital units are a provider type that enrolls via the Form CMS-855A. An exception to this is when the hospital is requesting enrollment to bill for practitioner services for hospital departments, outpatient departments, outpatient locations, and/or hospital clinics; in this circumstance, a new Form CMS-855B enrollment application is required.

2. Enrollment Information

a. Swing-Bed Designation

A “swing-bed” hospital is one that is approved by CMS to furnish post-hospital skilled nursing facility (SNF) services. That is, hospital (or critical access hospital (CAH)) patients’ beds can “swing” from furnishing hospital services to providing SNF care without the patient necessarily being moved to another part of the building. It receives a separate survey and certification from that of the hospital. Thus, if swing-bed designation is terminated, the hospital still maintains its certification. In addition, the hospital is given an additional CCN to bill for swing-bed services. (The third digit of the CCN will be the letter U, W, Y or Z.)

In general, and as stated in 42 CFR § 482.58, in order to obtain swing-bed status the hospital must, among other things: (1) have a Medicare provider agreement; (2) be located in a rural area; and (3) have fewer than 100 non-newborn or intensive care beds. Swing-bed hospitals, therefore, are generally small hospitals in rural areas where there may not be enough SNFs, and the hospital is thus used to furnish SNF services.

A separate provider agreement and enrollment for the swing-bed unit is not required. (The hospital’s provider agreement incorporates the swing-bed services.) The hospital can add the swing-bed unit as a practice location via the Form CMS-855A.

Additional data on “swing-bed” units can be found in Pub. 100-07, chapter 2, sections 2036 – 2040.

b. Psychiatric and Rehabilitation Units

Though these units receive a state survey, a separate provider agreement and enrollment is not required. (The hospital’s provider agreement incorporates these units.) The hospital can add the unit as a practice location to the Form CMS-855A.

c. Multi-Campus Hospitals

A multi-campus hospital (MCH) has two or more hospital campuses operating under one CCN. The MCH would report its various units/campuses as practice locations on the Form CMS-855A. For additional information on multi-campus hospitals, see Pub. 100-07, chapter 2, section 2024.

d. Physician-Owned Hospitals

As defined in 42 CFR § 489.3, a physician-owned hospital (POH) means any participating hospital (as defined in 42 CFR §489.24) in which a physician or an immediate family member of a physician has an ownership or investment interest in the hospital. The ownership or investment interest may be through equity, debt, or other means, and includes an interest in an entity that holds an ownership or investment interest in the hospital. (This definition does not include a hospital with physician ownership or investment interests that satisfy the requirements at 42 CFR § 411.356(a) or (b).)

Section 2(A)(4) of the Form CMS-855A asks the applicant to identify whether it is a physician-owned hospital. If the applicant indicates in Section 2(A)(2) that it is a hospital, it must complete Section 2(A)(4). Applicants that are not hospitals need not complete Section 2(A)(4).

At this time, POHs are not required to submit a completed Form CMS-855POH or a completed Attachment 1 of the Form CMS-855A. As stated in the March 12, 2015 announcement in MLN Connects Provider eNews, CMS has extended the deadline for the POH Initial Annual Ownership/Investment Report due to concerns about the accuracy of the data collected in the report. Future instruction regarding the reporting of POH ownership and investment will be provided on the CMS physician self-referral website.

e. Critical Access Hospitals

Critical access hospitals (CAHs) are not considered to be a hospital sub-type for enrollment purposes. CAHs instead must be enrolled as a separate, distinct provider type. Thus, if an existing hospital wishes to convert to a CAH, it must submit a Form CMS-855A as an initial enrollment.

f. Hospital Addition of Practice Location

In situations where a hospital is adding a practice location, the contractor shall notify the provider in writing that its recommendation for approval does not constitute approval of the facility or group as provider-based under 42 CFR § 413.65.

If the contractor makes a recommendation for approval of the provider's request to add a hospital unit, the contractor shall forward the package to the state agency as described in this chapter.

g. Transplant Programs

For purposes of Medicare enrollment, a hospital transplant program is treated similarly to a hospital sub-unit. If the hospital wishes to add a transplant program, it must check the "other" box in Section 2A2 of the Form CMS-855A, write "transplant program" on the space provided, and follow the standard instructions for adding a sub-unit. Unless CMS indicates otherwise, the contractor shall process the application in the same manner it would the addition of a hospital sub-unit; however, no separate enrollment in PECOS need be created for the transplant center.

3. Other Enrollment Procedures

Regarding Section 4 of the Form CMS-855A, the hospital must list all addresses where it - and not a separately enrolled provider or supplier it owns or operates, such as a nursing home - furnishes services. The hospital's primary practice location should be the first location identified in Section 4A and the contractor shall treat it as such – unless there is evidence indicating otherwise. **NOTE:** Hospital departments located at the same address as the main facility need not be listed as practice locations on the Form CMS-855A.

If an enrolled hospital seeks to add a rehabilitation, psychiatric, or swing-bed unit, it should submit a Form CMS-855 change of information request and not an initial enrollment application.

4. Non-Participating Emergency Hospitals, Veterans Administration (VA) Hospitals, and Department of Defense (DOD) Hospitals

Non-participating emergency hospitals, VA hospitals and DOD hospitals no longer need to complete a Form CMS-855A enrollment application in order to bill Medicare.

5. Form CMS-855B Applications Submitted by Hospitals

a. Group Practices

If an entity is enrolling via the Form CMS-855B as a hospital-owned clinic/physician practice, the contractor shall contact the applicant to determine whether the latter will be billing any of the listed locations as provider-based. If the applicant will not be billing as provider-based, the contractor shall process the application normally. If, however, the applicant will bill as provider-based, the contractor shall notify the applicant that the hospital must report any changed practice locations to its contractor via the Form CMS-855A.

If the supplier is enrolling as a hospital department (under the “Clinic/Group Practice” category on the Form CMS-855B) or an existing hospital department is undergoing a change of ownership (CHOW), the contractor shall only issue the necessary billing numbers upon notification that a provider agreement has been issued – or, in the case of a CHOW, the provider agreement has been transferred to the new owner. If, however, the supplier is enrolling as a group practice that is merely owned by a hospital (as opposed to being a hospital department), the contractor need not wait until the provider agreement is issued before conveying billing privileges to the group.

b. Individual Billings

Assume an individual physician works for a hospital and will bill for services as an individual (i.e., not as part of the hospital service/payment). However, he/she wants to reassign these benefits to the hospital. The hospital will need to enroll with the contractor via the Form CMS-855B (e.g., as a hospital department, outpatient location).

I. Indian Health Services (IHS) Facilities

1. 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 in Section 2A of the Form CMS-855A 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 an IHS facility is involved.

The overwhelming majority of IHS facilities on the Part A side are either hospitals, SNFs, CAHs, or ESRD 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 CCNs, 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.

2. Enrollment Information

IHS facilities and tribal providers may use Internet-based PECOS or the paper Form 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 3115
Mechanicsburg, PA 17055-1858

3. 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 such that licensed health professionals employed by a tribal health program are, if licensed in any state, exempt 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, therefore, 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 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 424.521(a) and section 10.6.2 of this chapter.

4. Additional Information

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

J. Organ Procurement Organizations (OPOs)

1. General Background Information

An OPO is an organization that performs or coordinates the procurement, preservation, and transport of organs and maintains a system for locating prospective recipients for available organs. An OPO must have been certified as a qualified OPO by CMS under 42 U.S.C. 273(b) and § 486.303 to be eligible for designation. In order to be certified as a qualified OPO, an OPO must have received a grant under 42 U.S.C. 273(a) or have been certified or re-certified by the Secretary within the previous four years as being a qualified OPO. Under the statute, no new OPOs can enroll into the Medicare program

2. Re-certification

An OPO is designated for a 4-year agreement cycle. The period may be shorter, for example, if an OPO has voluntarily terminated its agreement with CMS and CMS selects a successor OPO for the balance of the 4-year agreement cycle. Re-certification must occur not more frequently than once every 4 years. The SOG Location is responsible for conducting the re-certification surveys every 4 years; the OPO must sign a new provider agreement (Form CMS-576A) and participate in the Organ Procurement and Transplantation Network. (See CMS Pub. 100-07, chapter 2, sections 2810 and 2811.)

3. Change in Control/Ownership or Service Area

OPOs can undergo a change in control or ownership or service area (§ 486.310). The merger of one OPO into another or the consolidation of one OPO with another is considered a change in control or ownership. The OPO must notify CMS before implementing a change in ownership or control or a change in its service area. The OPO must provide the SOG Location with information that is specific to the board structure of the new organization, as well as operating budgets, financial information and other documentation that the SOG Location determines to be necessary. The OPO must also submit a revised Form CMS-855 to the MAC for review and a recommendation of approval from the SOG Location. When the SOG Location receives notification of a prospective change in control or ownership for a designated OPO, the SOG Location must determine (based upon the documents and information submitted) that the operation of the OPO will continue uninterrupted during and following the change. For any change of ownership or control, a new CMS Form-576 must be signed.

The instructions in the previous paragraph are in addition to, and not in lieu of, those pertaining to changes of ownership and referrals to SOG Locations in sections 10.6 and 10.6.1 of this chapter.

4. Additional Information

For more information on OPOs, refer to:

- Section 1138 of the Social Security Act
- 42 CFR § 486.301 - § 486.360
- Pub. 100-07, chapter 2, sections 2810 – 2821

For guidance on the appropriate contractor jurisdiction for incoming OPO applications, see CMS Pub. 100-04, chapter 1, section 20. Note that a hospital-based OPO must enroll separately, be separately certified, and sign its own provider agreement.

K. Outpatient Physical Therapy/Outpatient Speech Pathology Services (OPT/OSP)

1. General Background Information

Physical therapists and speech pathologists provide therapy targeting a person's ability to move and perform functional activities in their daily lives typically inhibited by illness or injury. Care is typically coordinated by therapists in conjunction with a physician and is based on an agreed upon plan of care.

2. Enrollment Information

a. Providers of OPT/OSP Services

As explained in Pub. 100-07, chapter 2 section 2292, there are three types of organizations that may qualify as providers of OPT and OSP services under 42 CFR Part 485, Subpart H: clinics, public health clinics, and rehabilitation agencies. However, rehabilitation agencies are the only organizations that are currently enrolled as a Medicare provider with a CCN. The primary purpose of a rehabilitation agency is to improve or rehabilitate an injury or disability and to tailor a rehabilitation program to meet the specific rehabilitation needs of each patient referred to the agency. A rehabilitation agency must provide, at a minimum, physical therapy and/or speech language pathology services to address those needs of the patients. Social/vocational services are no longer a requirement.

Note that:

- If an OPT/OSP provider elects to convert to a CORF, it must meet the CORF conditions of coverage and participation. An initial Form CMS-855A enrollment application, state survey, and CMS program approval are also required.
- Only those OPT/OSP providers covered under 42 CFR Part 485, Subpart H that furnish OPT/OSP services (as listed above) have provider agreements under 42 CFR § 489.2. Part B physician groups – the supplier type that most people normally associate with the term “clinics” – do not have certified provider or certified supplier agreements.
- Occupational therapy cannot be substituted for the physical therapy requirement. It may, however, be provided in addition to physical therapy or speech pathology services. (See Pub. 100-07, chapter 2, section 2292A.)

b. Extension Locations

As discussed in Pub. 100-07, chapter 2, sections 2298 and 2298A, an OPT/OSP provider can, in certain instances, furnish services from locations other than its primary site. (The provider must designate one location as its primary location on the Form CMS-855A, however.) These sites are called extension locations. An extension location is defined at 42 CFR § 485.703 as “a location or site from which a rehabilitation agency provides services within a portion of the total geographic area served by the primary site. The extension location is part of the agency. The extension location should be located sufficiently close to share administration, supervision, and services in a manner that renders it unnecessary for the extension location to independently meet the conditions of participation as a rehabilitation agency.” Per Pub. 100-07, chapter 2, section 2298A, only rehabilitation agencies are permitted to have extension locations. The clinics

operated by physicians and public health clinics are not permitted extension locations. These two providers must provide outpatient therapy services at their Medicare approved location.

An OPT/OSP provider may also furnish therapy services in a patient's home or in a patient's room in a SNF. (See Pub. 100-07, chapter 2, section 2300. Note that when the OPT provides services away from the primary site or extension location(s), this is referred to as "off-premises activity" at other locations. Section 2300 (referenced) above discusses such activities.) Because these are not considered extension locations, neither the home nor the patient's room need be listed as a practice location on the provider's Form CMS-855A. (See Pub. 100-07, chapter 2, section 2298B.)

If an OPT/OSP provider wants to add an extension site, a Form CMS-855A change of information request should be submitted.

There is no prohibition against an organization operating on the premises of a supplier (e.g., physician or chiropractor) or another provider as long as they are not operating in the same space at the same time. (See Pub. 100-07, chapter 2, section 2304.)

c. For more information on OPT/OSP providers, refer to:

- Section 1861(p) of the Social Security Act
- 42 CFR Part 485, subpart H
- Pub. 100-07, chapter 2, sections 2290 – 2308
- Pub. 100-07, Appendix E

L. Religious Non-Medical Health Care Institutions (RNHCIs)

1. General Background Information

RNHCIs furnish only nonmedical nursing services and items to people who choose to rely solely on obtaining a religious method of healing and for whom the acceptance of medical services would be inconsistent with their religious views. Such nonmedical services are performed exclusively through nonmedical nursing personnel who are experienced in caring for the physical needs of nonmedical patients (e.g., caring for the physical needs such as assistance with activities of daily living; assistance in moving, positioning, and ambulation; nutritional needs; and comfort and support measures). RNHCIs do not perform any medical screenings, examinations, diagnoses, or treatments, including the administration of drugs. Each beneficiary who wishes to receive services in an RNHCI must make a valid and formal written statement (or "election") to do so. (The specific election requirements are discussed in 42 CFR § 403.724 and Pub. 100-07, chapter 2, section 2054.1B.)

CMS's Boston Northeast SOG Location (in coordination with the CMS Central Office) has primary responsibility over the approval and certification of RNHCIs. RNHCIs are not certified by the state but must meet all of the conditions of coverage outlined in 42 CFR §403.720 as well as all conditions of participation. (See 42 CFR §§ 403.730 through 403.746 regarding RNCHI conditions of participation.) For purposes of provider enrollment, the three most important conditions are that the provider:

- a. Must not be owned by, under common ownership with, or have an ownership interest of 5 percent or more in a provider of medical treatment or services.
- b. Must not be affiliated with a provider of medical treatment or services or with an individual who has an ownership interest of 5 percent or more in a provider of medical treatment or services. (Permissible affiliations are described in 42 CFR § 403.738(c)).
- c. Must be a non-profit organization per subsection (c)(3) of § 501 of the Internal Revenue Code of 1986, and exempt from taxes under subsection 501(a).

(See Pub. 100-07, chapter 2, section 2054.1 for additional conditions.)

To this end, the contractor shall (1) examine sections 5 and 6 of the Form CMS-855A and (2) verify the provider's non-profit status to ensure that the aforementioned conditions are met.

2. Additional Information

For more information on RNCHIs, refer to:

- Section 1861(ss)(1) of the Social Security Act
- 42 CFR Part 403, subpart G
- Pub. 100-07, chapter 2, sections 2054, 2054.1, 2054.1A and 2054.1B
- Pub. 100-04, chapter 3, sections 170 - 180
- Pub. 100-02, chapter 1, sections 130 – 130.4.2

For guidance on the appropriate contractor jurisdiction for incoming RNCHI applications, please see Pub. 100-04, chapter 1, section 20.

M. Rural Health Clinics (RHCs)

1. General Background Information

An RHC is a facility located in a rural area designated as a shortage area and is neither a rehabilitation agency nor a facility primarily for the care and treatment of mental diseases. It must meet all other requirements of the RHC regulations at 42 CFR Part 491, subpart A. RHCs:

- Are considered to be Part B certified suppliers even though they enroll in Medicare via the Form CMS-855A.
- Are defined in section 1861(aa)(2) of the Social Security Act as facilities that are engaged primarily in providing services that are typically furnished in an outpatient clinic.
- Sign a supplier agreement with CMS (akin to those signed by certified providers). Specifically, RHCs sign the Health Insurance Benefit Agreement (Form CMS-1561A).

- Can be either mobile in nature or fixed/permanent locations.
- Can be freestanding or provider-based. (As stated in Pub. 100-07, provider-based RHCs are an integral and subordinate part of a hospital (including a critical access hospital (CAH), skilled nursing facility (SNF), or a home health agency (HHA)).

There are certain services performed by RHCs that do not actually qualify as RHC services. To bill for these services, the clinic must enroll as a Clinic/Group Practice via the Form CMS-855B. It is not uncommon to see RHCs simultaneously enrolled in Medicare via the Form CMS-855A (to bill for RHC services) and the Form CMS-855B (to bill for non-RHC services).

Note that a facility cannot be simultaneously enrolled as an FQHC and an RHC. Though there are similarities between these two supplier types, there are key differences as well. For instance, FQHCs can service rural or urban regions. To be eligible for certification as an RHC, however, a clinic must be located in a non-urbanized area, as determined by the U.S. Census Bureau, and in an area designated or certified within the previous 4 years by the Secretary of Health and Human Services (HHS), in any one of the four types of shortage area designations that are accepted for RHC certification. (See Pub. 100-02, chapter 13, sections 10.1 and 20.) Also: (1) RHCs are surveyed by the state while FQHCs are not; and (2) FQHCs furnish preventive services while RHCs do not.

2. Additional Information

For more information on RHCs, refer to:

- Section 1861(aa)(1-2) of the Social Security Act
- 42 CFR Part 491, subpart A
- Pub. 100-07, chapter 2, sections 2240 – 2249
- Pub. 100-04, chapter 9
- Pub. 100-02, chapter 13

For guidance on the appropriate contractor jurisdictions for incoming RHC applications, refer to Pub. 100-04, chapter 1, section 20.

N. Skilled Nursing Facilities (SNFs)

1. General Background Information

As stated in Pub. 100-07, chapter 7, section 7004.2, a SNF is a facility that:

- Is primarily engaged in providing to residents skilled nursing care and related services for residents who require medical or nursing care; or
- Is primarily engaged in providing to residents skilled rehabilitation services for the rehabilitation of injured, disabled, or sick persons; while the care and treatment of mental disease is not the primary action of SNFs, the ability to provide appropriate resources and support for these beneficiaries is necessary;
- Has in effect a transfer agreement (meeting the requirements of §1861(1) of the Social Security Act with one or more hospitals having agreements in effect under § 1866 of the Social Security Act); and
- Meets the requirements for a skilled nursing facility described in subsections (b), (c), and (d) of §1819 of the Social Security Act.

The transfer agreement mentioned above need not be submitted with the SNF's Form CMS-855A enrollment application; the state and/or SOG Location will verify that the agreement exists.

Like other certified providers, SNFs receive a state survey and sign a provider agreement. SNFs cannot have multiple practice locations under one Form CMS-855A enrollment.

2. SNF Distinct Parts

A SNF can be a separate institution or a “distinct part” of an institution. The term “distinct part” means an area or portion of an institution (e.g., a hospital) that is certified to furnish SNF services. The hospital and the SNF distinct part will each receive a separate CCN. Also:

- A hospital may have only one SNF distinct part.
- “Distinct part” designation is not equivalent to being “provider-based.”

A SNF distinct part unit must enroll separately (i.e., it cannot be listed as a practice location on the hospital's Form CMS-855A), be separately surveyed, and sign a separate provider agreement. (Note how this is different from “swing-bed” units, which do not enroll separately and do not sign separate provider agreements.)

3. Additional Information

For more information on SNFs, refer to:

- Section 1819 of the Social Security Act
- Pub. 100-07, chapter 7
- Pub. 100-02, chapter 8

10.2.2 – Suppliers That Enroll Via the Form CMS-855B (Rev. 10611; Issued: 03-19-21; Effective:11-19-20; Implementation: 11-19-20)

A. Ambulatory Surgical Centers (ASCs)

ASCs are a certified supplier type that enroll via the Form CMS-855B.

1. General Background Information

An ASC is defined in 42 CFR §416.2 as any distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization and in which the expected duration of services would not exceed 24 hours following an admission; the entity must have an agreement with CMS to participate in Medicare as an ASC, and must meet the conditions set forth in 42 CFR Part 416, subparts B and C (The ASC supplier agreement (Form CMS-370) is similar to the provider agreement signed by Part A providers.)

As stated in §416.26(a), CMS may deem an ASC to be in compliance with any or all of the ASC conditions of coverage if:

- The ASC is accredited by a national accrediting body, or licensed by a state agency, that CMS determines provides reasonable assurance that the conditions are met;
- In the case of deemed status through accreditation by a national accrediting body, where state law requires licensure, the ASC complies with state licensure requirements; and
- The ASC authorizes the release to CMS of the findings of the accreditation survey.

Unless CMS deems the ASC to be in compliance with the ASC conditions of coverage, a state survey will be performed.

Note: ASCs can be fixed locations or mobile in nature.

2. Additional Enrollment Information

The contractor shall include any licenses, certifications, and accreditations submitted by ASCs in the enrollment package that is forwarded to the state and/or RO.

Once the contractor receives the approval letter or tie-in notice from the RO for an ASC supplier, the contractor is encouraged, but not required, to contact the RO, state agency, or supplier for the applicable licensing and/or certification data and to enter it into PECOS.

If the ASC applicant's address or telephone number cannot be verified, the contractor shall contact the applicant for further information. If the supplier states that the facility or its phone number is not yet operational, the contractor shall continue processing the application. However, it shall indicate in its recommendation letter that the address and telephone number of the facility could not be verified.

For purposes of PECOS entry, the contractor can temporarily use the date the certification statement was signed as the effective date.

3. Ambulatory Surgical Centers (ASCs) and Reassignment

Physicians and non-physician practitioners who meet the reassignment exceptions in 42 CFR §424.80, and Pub. 100-04, chapter 1, sections 30.2.6 and 30.2.7, may reassign their benefits to an ASC.

If a physician or non-physician practitioner wishes to reassign its benefits to an existing (that is, a currently-enrolled) ASC, both the individual and the entity must sign the CMS-855R. However, it is not necessary for the ASC to separately enroll as a group practice in order to receive benefits. It can accept reassignment as an ASC.

4. Ambulatory Surgical Centers (ASCs) - Initial Enrollment

Unlike other supplier types that enroll via the Form CMS-855B, ASCs 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.

When enrolling the ASC, 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 10.6.1(B)(5) of this chapter for more information on ASC tie-in notices/approval letters.

5. Ambulatory Surgical Centers (ASCs) Changes of Ownership (CHOWs)

Though ASCs are not mentioned in 42 CFR § 489.18, CMS generally applies the change of ownership (CHOW) provisions of § 489.18 to them. CHOWs involving ASCs are thus handled in accordance with the principles in §489.18 and Publication 100-07, chapter 3, sections 3210 through 3210.5(C). Note that the RO – not the contractor – determines whether a CHOW has occurred (unless this function has been delegated).

As discussed in section 10.2.2(A)(5) of this chapter, an ASC must sign a supplier agreement with Medicare prior to enrollment.

6. ASCs and CHOWs

If – pursuant to the CHOW – the seller submits a Form CMS-855B voluntary termination application, the contractor shall contact and explain to the seller that the ambulatory surgical center will not receive any payments until the RO approves the CHOW. (This is because payments must be sent to the seller until the tie-in/approval letter is sent). If the seller insists that its application be processed, the contractor shall process it; however, it shall first notify the facility/new owner and explain that payments will cease once the seller's termination is effective.

7. Additional Information

For more information on ASCs, refer to:

- 42 CFR Part 416
- Pub. 100-07, State Operations Manual, chapter 2, section 2210 and Appendix L
- Pub. 100-02, Benefit Policy Manual, chapter 15, sections 260 – 260.5.3
- Pub. 100-04, Claims Processing Manual, chapter 14

- Also, see Pub. 100-07, State Operations Manual, chapter 2, section 2210, for information regarding the sharing of space between ASCs and other providers.

8. ASCs and Hospitals

See the following instructions for guidance regarding hospital-operated/affiliated ASCs:

- Pub. 100-04, Claims Processing Manual, chapter 14, section 10.1
- Pub. 100-02, Benefit Policy Manual, chapter 15, section 260.1

B. CLIA Labs

CLIA Labs are a certified supplier type that enroll via the Form CMS-855B.

1. General Background Information

As explained in Pub. 100-07, State Operations Manual, chapter 6, sections 6000 and 6002, the Clinical Laboratory Improvement Amendments of 1988 (CLIA) amended the Public Health Service Act (42 U.S.C. 263a) to extend jurisdiction of the Department of Health and Human Services (HHS) to regulate all laboratories that test human specimens for the purpose of providing information for diagnosis, prevention, or treatment of any disease or impairment of, or the assessment of the health of, human beings. CLIA mandates that virtually all laboratories, including physician office laboratories, meet applicable Federal requirements and have a CLIA certificate in order to operate.

Regulations implementing CLIA are codified under 42 CFR Part 493. These regulations require that all laboratories or entities that perform laboratory testing:

- Pay user fees as assessed by CMS to finance the entire cost of administering the CLIA program;
- Submit specific information to HHS or its designee;
- Comply with specific administrative and program requirements;
- Submit to surveys to assess compliance with CLIA requirements;
- Be subject to specified enforcement actions; and
- Apply for CLIA certificates based on the complexity of testing performed in the laboratory or based on accreditation by a CMS-approved accreditation organization, or
- Be located in a State with a CMS approved State laboratory licensure program, be licensed or approved in accordance with state requirements.

Section 6141 of the Omnibus Budget Reconciliation Act of 1989 requires that laboratories participating in the Medicare program comply with CLIA requirements. Therefore, all laboratories, with the exception of laboratories licensed by a state with a CMS-approved state laboratory licensure program (CLIA-exempt laboratories) must obtain a CLIA certificate to operate and to be eligible for payment under Medicare and Medicaid. Although CLIA-exempt laboratories do not need a CLIA certificate to operate, they are assigned a CLIA identification number for Medicare and Medicaid payment purposes.

Certain types of laboratories and laboratory tests are NOT subject to meeting CLIA requirements. These include:

- Any facility or component of a facility that performs testing strictly for forensic purposes;
- Research laboratories that do not report patient specific results (although they test human specimens) for the diagnosis, prevention or treatment of any disease or impairment of, or the assessment of the health of individuals;
- Components or functions of laboratories certified by the Substance Abuse and Mental Health Services Administration (SAMHSA), in which drug testing is performed that meets SAMHSA guidelines and regulations. (However, all other testing conducted by a SAMHSA certified laboratory is subject to this rule.);
- Laboratories under the jurisdiction of the Department of Veterans Affairs;
- Department of Defense (DoD) laboratories are subject to requirements that CMS has determined to be comparable to those in CLIA. The DoD is responsible for assuring compliance with these requirements and for oversight of its laboratories under a Memorandum of Understanding (MOU) between the Secretary of HHS and the Secretary of DoD. (See §6022 for discussions on Federal laboratories.);
- Laboratory testing conducted in conjunction with the provision of home health or hospice care in an individual's home, where the home health agency or hospice employee merely **assists** the individual in performing a test, since tests performed by individuals in the home are not subject to CLIA;
- Laboratories licensed in a state whose laboratory licensure program is approved by CMS, (i.e., CLIA exempt as approved under 42 CFR part 493, Subpart E);
- Facilities which serve only as collection stations. A collection station receives specimens to be forwarded to a laboratory performing diagnostic tests;
- Radiological facilities that perform only imaging procedures (e.g., x-rays, ultrasounds, Magnetic Resonance Imaging, Computerized Tomography);

- Facilities performing only physiological testing, e.g. spirometry, slit-lamp test for eyes, breath analysis, pulse oximetry; and
- Any facility or component of a facility that performs testing for drugs of abuse for employment purposes.

2. Certificates

See Pub. 100-07, State Operations Manual, chapter 6, sections 6006 through 6006.7 for information regarding the various types of CLIA certificates.

3. CLIA Enrollment

Unless stated otherwise in this chapter or in another CMS directive:

- Each practice location at which laboratory tests are performed must submit to the contractor a separate CLIA certificate for that location. The only exceptions to this rule are:
 - Laboratories within a hospital that are located at contiguous buildings, on the same campus, and under common direction;
 - Non-profit or governmental laboratories that engage in limited public health testing;
 - Laboratories that are not at a fixed location (i.e., are mobile)
- (See Pub. 100-07, State Operations Manual, chapter 6, sections 6008, 6026, and 6034 through 6036.3 for more information, including guidance relating to home health agencies and hospices.)
- The laboratory must submit to the contractor a separate certificate for each state in which testing is performed.
- If a lab is under the same ownership and at the same location as the “main provider,” it generally does not need to enroll separately. The enrolling provider will simply furnish its CLIA number in the practice location section. Conversely, if a lab is an “independent CLIA lab,” it must enroll separately.
- A separate enrollment record need not be created for each CLIA number. For instance, suppose a physician is enrolling in Medicare and has a CLIA number. The contractor need only create a single enrollment record that will encompass the Medicare number and the CLIA number.

4. Procedure to Update CLIA Certificate for an Enrolled CLIA lab

A Medicare-enrolled CLIA lab shall submit the updated CLIA Certificate to its contractor with a CMS-855. The MAC shall update PECOS accordingly, regardless if the provider or supplier is in PECOS.

5. Site Visits of Independent CLIA Labs

- a. Initial application – If an independent CLIA lab 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 still in compliance with CMS’s enrollment requirements. The scope of the site visit will be consistent with Section 10.6.20(A) and 10.6.20(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.
- b. Revalidation – If an independent CLIA lab 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 10.6.20(A) and 10.6.20(B) of this chapter. The NSVC will perform the site visit. The contractor shall not make a final decision regarding the revalidation application prior to the completion of the NSVC’s site visit and the contractor’s review of the results.
- c. New/changed location - If an independent CLIA lab 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 before the contractor switches the supplier’s enrollment record to “Approved.” 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 10.6.20(A) and 10.6.20(B) of this chapter. The NSVC will perform the site visit. The contractor shall not switch the supplier’s enrollment record to “Approved” prior to the completion of the NSVC’s site visit and the contractor’s review of the results.

6. Integrated CLIA Labs

Labs that are “integrated” into an existing provider or supplier do not require a separate Form CMS-855B enrollment. “Integrated” labs typically are those that have exactly the same ownership and physical location as another enrolled supplier or provider. (Common examples include: (1) hospital labs and (2) a lab at a physician's office.) If a lab is considered “integrated,” the parent provider shall identify the lab as a practice location in section 4 of its Form CMS-855.

If the lab is not “integrated,” the lab must enroll as an independent CLIA lab via the Form CMS-855B application. The contractor shall advise the lab that it must contact the applicable CLIA office; the lab cannot be enrolled until it receives a CLIA number. The contractor shall also ensure that the lab is CLIA-certified and, as applicable, State-licensed.

Labs that do not plan to participate in the Medicare program must be directed to the applicable CLIA office.

7. Additional Information

For additional data on CLIA laboratories, refer to:

- 42 CFR Part 493
- Publication 100-07, State Operations Manual, chapter 6 (in full)
- Publication 100-04, Claims Processing Manual, chapter 16
- Form CMS-116 (CLIA Application for Certification)

C. Mammography Screening Centers

Mammography Screening Centers are a certified supplier type that enroll via the Form CMS-855B.

1. General Background Information

As defined in 42 CFR § 410.34(a)(2), a screening mammography is a radiologic procedure “furnished to a woman without signs or symptoms of breast disease, for the purpose of early detection of breast cancer, and includes a physician's interpretation of the results of the procedure.” Section 410.34(a)(4) defines a “supplier of screening mammography” as “a facility that is certified and responsible for ensuring that all screening mammography services furnished to Medicare beneficiaries meet the conditions and limitations for coverage of screening mammography services as specified in (§ 410.34)(c) and (d).”

2. Enrollment of Mammography Screening Centers

To enroll in Medicare, a mammography screening center must have a valid provisional certificate, or a valid certificate, that has been issued by the Food and Drug Administration (FDA) indicating that the supplier meets the certification requirements of section 354 of the PHS Act, as implemented by 21 CFR Part 900, subpart B. (The FDA is responsible for collecting certificate fees and surveying mammography facilities (screening and diagnostic).) Unless stated otherwise in this chapter or in another CMS directive, the supplier shall submit a copy of its FDA certificate with its application. If the supplier fails to submit the FDA certificate within 30 days of the MAC's request the MAC shall follow the rejection instructions within Section 10.4(H)(2) of this chapter.

It is important that the contractor review and adhere to the following regulations and instructions regarding the required qualifications of mammography screening centers:

- 42 CFR § 410.34 (in full)
- Pub. 100-04, Claims Processing Manual, chapter 18, sections 20 through 20.1.2
- Pub. 100-02, Benefit Policy Manual, chapter 15, section 280.3

D. Pharmacies

Pharmacies are a supplier type that enroll via the Form CMS-855B

1. General Background Information

Pharmacies typically enroll with the National Supplier Clearinghouse via the Form CMS-855S. However, there are certain covered drugs that are billed through the physician fee schedule and not the schedule for durable medical equipment, prosthetics, orthotics and supplies. These drugs must be billed to the Part A/B MAC, meaning that the pharmacy must enroll with the Part A/B MAC via the Form CMS-855B.

2. Additional Information

For more information on the billing and coverage policies for Part B drugs, see:

- Pub. 100-04, Claims Processing Manual, chapter 17
- Pub. 100-02, Benefit Policy Manual, chapter 15, sections 50 through 50.6

E. Portable X-Ray Suppliers (PXRSSs)

PXRSSs are a certified supplier type that enroll via the Form CMS-855B.

1. General Background Information

To qualify as a portable x-ray supplier (PXRSS), an entity must meet the conditions for coverage discussed in 42 CFR § 486.100-110.

A PXRSS can be simultaneously enrolled as a mobile IDTF, though they cannot bill for the same service. A PXRSS requires a State survey, while a mobile IDTF does not (although an IDTF requires a site visit).

A PXRSS does not have a supplier agreement.

2. Enrollment of PXRSSs

a. Initial application

Unlike other supplier types that enroll via the Form CMS-855B, PXRSSs 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 a follow-up site visit is performed per section 10.2.2(E)(3) of this chapter.

When enrolling the PXRSS, 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 10.6.1(B)(5) of this chapter for more information on PXRSS tie-in notices/approval letters.

b. Practice Location Information

- In order to enroll as a PXRS, a supplier must complete a Form CMS-855B, undergo a State survey, and obtain RO approval. In Section 4 of the Form CMS-855B, the PXRS must furnish certain information, including:
 - Whether it furnishes services from a “mobile facility” or “portable unit.” The former term typically describes a vehicle that travels from place to place to perform services inside the vehicle. Examples of such vehicles include mobile homes or trailers. A “portable unit” exists when a supplier transports medical equipment to a particular location. Unlike with mobile facilities, the equipment on a portable unit is separate from and unattached to the vehicle.
 - A PXRS can be either a mobile facility or portable unit, although it usually is the latter. A mobile IDTF, on the other hand, while it too can be either, is typically a mobile facility.
 - Its base of operations. This is where personnel are dispatched from and where equipment is stored. It may or may not be the same address as the practice location.
 - All geographic locations at which services will be rendered.
 - Vehicle information if the services will be performed inside or from the vehicle. Copies of all licenses and registrations must be submitted as well, unless stated otherwise in this chapter or in another CMS directive.

3. Site Visits

If a PXRS submits an initial application, the contractor shall order a site visit through the Provider Enrollment, Chain and Ownership System (PECOS) after the contractor receives the tie-in notice (or approval letter) from the RO but before the contractor conveys Medicare billing privileges to the PXRS. 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 10.6.20(A) and 10.6.20(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.

a. New/changed location

If a PXRS 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 after the contractor receives notice of approval from the RO but before the contractor switches the supplier’s enrollment record to “Approved.” 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 10.6.20(A) and 10.6.20(B) of this chapter. The NSVC will perform the site visit. The contractor shall not switch the supplier's enrollment record to "Approved" prior to the completion of the NSVC's site visit and the contractor's review of the results.

b. Revalidation

If a PXRS 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 10.6.20(A) and 10.6.20(B) of this chapter. The NSVC will perform the site visit. The contractor shall not make a final decision regarding the revalidation application prior to the completion of the NSVC's site visit and the contractor's review of the results.

c. Reassignment

PXRSs may receive reassigned benefits. A PXRS need not separately enroll as a group practice in order to receive them.

4. Additional Enrollment Information

The contractor shall include any licenses, certifications, and accreditations submitted by portable x-ray suppliers in the enrollment package that is forwarded to the state and/or RO.

Once the contractor receives the approval letter or tie-in notice from the RO for a portable x-ray supplier, the contractor is encouraged, but not required, to contact the RO, state agency, or supplier for the applicable licensing and/or certification data and to enter it into PECOS.

If the portable x-ray supplier's address or telephone number cannot be verified, the contractor shall contact the applicant for further information. If the supplier states that the facility or its phone number is not yet operational, the contractor shall continue processing the application. However, it shall indicate in its recommendation letter that the address and telephone number of the facility could not be verified.

For purposes of PECOS entry, the contractor can temporarily use the date the certification statement was signed as the effective date.

5. PXRS and CHOWs

Though PXRSs are not mentioned in 42 CFR § 489.18, CMS generally applies the change of ownership (CHOW) provisions of § 489.18 to them. CHOWs involving PXRSs are thus handled in accordance with the principles in §489.18 and Publication 100-07, chapter 3, sections 3210 through 3210.5(C). Note that the RO – not the contractor – determines whether a CHOW has occurred (unless this function has been delegated).

If – pursuant to the CHOW – the seller submits a Form CMS-855B voluntary termination application, the contractor shall contact and explain to the seller that the portable x-ray supplier will not receive any payments until the RO approves the CHOW. (This is because payments must be sent to the seller until the tie-in/approval letter is sent). If the seller insists that its application be processed, the contractor shall process it; however, it shall first notify the facility/new owner and explain that payments will cease once the seller's termination is effective.

6. Additional Information

For more information on PXRSSs, refer to:

- 42 CFR §§ 486.100 – 486.110
- Pub. 100-07, State Operations Manual, chapter 2, sections 2420 – 2424B
- Pub. 100-02, Benefit Policy Manual, chapter 15, sections 80.4 – 80.4.4
- Pub. 100-04, Claims Processing Manual, chapter 13, sections 90 – 90.5

F. Radiation Therapy Centers (RTCs)

RTCs are a supplier type that enroll via the Form CMS-855B.

1. General Background Information

Under 42 CFR § 410.35, Medicare Part B pays for X-ray therapy and other radiation therapy services, including radium therapy and radioactive isotope therapy, and materials and the services of technicians administering the treatment.

RTCs may receive reassigned benefits. An RTC need not separately enroll as a group practice in order to receive them.

2. Additional Information

For additional background on radiation therapy services, see:

- 42 CFR § 410.35
- Pub. 100-04, Claims Processing Manual, chapter 13
- Pub. 100-02, Benefit Policy Manual, chapter 15, section 90

G. Suppliers of Ambulance Services

Suppliers of Ambulance Services are supplier types that enroll via the Form CMS-855B.

1. General Background Information

It is important that the contractor review and adhere to the following regulations and instructions regarding the required qualifications of ambulance suppliers:

- 42 CFR §§ 410.40 and 410.41
- Pub. 100-02, Benefit Policy Manual, chapter 10 (in full)
- Pub. 100-04, Claims Processing Manual, chapter 15

2. Types of Ambulance Services

As stated in 42 CFR § 410.40, there are several types of ambulance services covered by Medicare. They are generally defined in § 414.605 as follows:

- a. Advanced Life Support, level 1 (ALS1) - Transportation by ground ambulance vehicle, medically necessary supplies and services, and either an ALS assessment by ALS personnel or the provision of at least one ALS intervention.
- b. Advanced Life Support, level 2 (ALS2) - Either transportation by ground ambulance vehicle, medically necessary supplies and services, and the administration of at least three medications by intravenous push/bolus or by continuous infusion, excluding crystalloid, hypotonic, isotonic, and hypertonic solutions (Dextrose, Normal Saline, Ringer's Lactate); or transportation, medically necessary supplies and services, and the provision of at least one of the seven ALS procedures specified in § 414.605.
- c. Air Ambulance (Fixed-Wing and Rotary-Wing) (See § 414.605 for specific definitions of fixed-wing and rotary-wing).
- d. Basic Life Support (BLS) - Transportation by ground ambulance vehicle and medically necessary supplies and services, plus the provision of BLS ambulance services. The ambulance must be staffed by an individual who is qualified in accordance with state and local laws as an emergency medical technician-basic (EMT-Basic).
- e. Paramedic ALS Intercept Services (PI) - Per § 414.605, EMT-Paramedic services furnished by an entity that does not furnish the ground transport, provided that the services meet the requirements in § 410.40(c). PI typically involves an arrangement between a BLS ambulance supplier and an ALS ambulance supplier, whereby the latter provides the ALS services and the BLS supplier provides the transportation component. Under § 410.40(c), PI must meet the following requirements:
 - Be furnished in an area that is designated as a rural area (see § 410.40(c)(1) for more information on this requirement)
 - Be furnished under contract with one or more volunteer ambulance services that meet the following conditions:

- Are certified to furnish ambulance services as required under § 410.41;
 - Furnish services only at the BLS level; and
 - Be prohibited by state law from billing for any service
 - Be furnished by a paramedic ALS intercept supplier that meets the following conditions:
 - Is certified to furnish ALS services as required in § 410.41(b)(2); and
 - Bills all the beneficiaries who receive ALS intercept services from the entity, regardless of whether or not those beneficiaries are Medicare beneficiaries.
- f. Specialty Care Transport (SCT) - Inter-facility transportation of a critically injured or ill beneficiary by a ground ambulance vehicle, including medically necessary supplies and services, at a level of service beyond the scope of the EMT-Paramedic. SCT is necessary when a beneficiary's condition requires ongoing care that must be furnished by one or more health professionals in an appropriate specialty area (e.g., nursing, emergency medicine, respiratory care, cardiovascular care, or a paramedic with additional training.)

3. Ambulance Qualifications

a. Vehicle Design and Equipment

Section 410.41(a) states that a vehicle used as an ambulance must meet the following requirements:

- Be specially designed to respond to medical emergencies or provide acute medical care to transport the sick and injured and comply with all state and local laws governing an emergency transportation vehicle.
- Be equipped with emergency warning lights and sirens, as required by state or local laws.
- Be equipped with telecommunications equipment as required by state or local law to include, at a minimum, one two-way voice radio or wireless telephone.
- Be equipped with a stretcher, linens, emergency medical supplies, oxygen equipment, and other lifesaving emergency medical equipment as required by state or local laws.

b. Vehicle Personnel

Per 42 CFR § 410.41(b)(1)(i) and (ii), a BLS vehicle must be staffed by at least two people, one of whom must be: (1) certified as an emergency medical technician by the state or local authority where the services are

furnished, and (2) legally authorized to operate all lifesaving and life-sustaining equipment on board the vehicle.

An ALS vehicle, in addition to meeting the BLS vehicle staff requirements described in 42 CFR § 410.41(b)(1), must also have one of the two staff members be certified as a paramedic or an emergency medical technician, by the state or local authority where the services are being furnished, to perform one or more ALS services.

4. Completion of the Form CMS-855B

Pub. 100-02, chapter 10, section 10.1.3 states that, in determining whether the vehicles and personnel of the ambulance supplier meet all of the above requirements, the contractor may accept the supplier's statement (absent information to the contrary) that its vehicles and personnel meet all of the requirements if the statement itself meets the requirements of section 10.1.3. However, section 10.1.3 does not obviate the need for the supplier to complete and submit to the contractor the Form CMS-855B (including Attachment 1 and all supporting documents), and does not excuse the contractor from having to verify the data on the Form CMS-855B in accordance with this chapter and all other applicable CMS instructions. In other words, the "statement" referred to in section 10.1.3, does not supplant or replace the Form CMS-855B enrollment process.

5. Geographic Area: Single Contractor Jurisdiction

If an ambulance company will be furnishing all of its services in the same contractor jurisdiction, the supplier should list:

- Each site at which its vehicles are garaged in section 4A. (The site is considered a practice location for enrollment purposes, including with respect to payment of the application fee.)
- Each site from which its personnel are dispatched in section 4A. (The site is considered a practice location for enrollment purposes, including with respect to payment of the application fee.)
- Its base of operations – which, for ambulance companies, is their primary headquarters – in section 4E. (The supplier can only have one base of operations.)

If the supplier will be furnishing services in more than one contractor jurisdiction, it shall follow the applicable instructions below.

6. Geographic Area: Multiple States

The applicant must list the geographic areas in which it provides services. If the supplier indicates that it provides services:

- In more than one contractor's jurisdiction, it must submit a separate Form CMS-855B to each contractor.

- In more than one state but within the same contractor jurisdiction, the contractor shall review section 10.2.2(G)(6) of this chapter to determine whether a separate enrollment for the additional state is required.

7. Practice Location

For purposes of provider enrollment, the following are considered ambulance “practice locations”:

- A site at which the supplier’s vehicles are garaged
- A site from which the supplier’s personnel are dispatched
- The supplier’s base of operations (i.e., the supplier’s primary headquarters). The supplier can only have one base of operations.

Hence, if an ambulance supplier submits a Form CMS-855B to add to its enrollment record a site at which the supplier’s vehicles are garaged or from which personnel are dispatched, the supplier must pay an application fee.

Consider the following scenarios:

- a. The ambulance supplier is enrolling and performing services in multiple states but within only 1 contractor jurisdiction: The supplier would have to list on its Form CMS-855B each city/state/zip code in which it performs services. Its base of operations and all other practice locations would also have to be listed, and all licensure/certification requirements would have to be met for each state in which it performs services. However, separate Form CMS-855B applications for each state would only be required if all 5 conditions described in Section 10.3.1(B)(1)(d)(iii) of this chapter are met. (If separate applications are not required, the contractor shall still create a separate Provider Enrollment, Chain and Ownership System (PECOS) record for each state.)
- b. The ambulance supplier is enrolling (and has its base of operations) in Contractor Jurisdiction X. Its vehicles perform services in X and in adjacent Contractor Jurisdiction Y: The supplier would have to enroll with X and Y. For its Contractor X CMS-855B, the supplier would have to list all of the data mentioned in Example (a) above. For its Contractor Y CMS-855B, the supplier would have to (1) list the cities/zip codes in Y in which it performs services, (2) list its Jurisdiction X base of operations and any practice locations in Jurisdiction Y, and (3) meet all licensure/certification requirements for the state(s) in Y in which the supplier performs services.

8. Licensure Information

With respect to licensure:

- The contractor shall ensure that the supplier is appropriately licensed and/or certified, as applicable.

- An air ambulance supplier that is enrolling in a State to which it flies in order to pick up patients (that is, a State other than where its base of operations is located) is not required to have a practice location or place of business in that State. So long as the air ambulance supplier meets all other criteria for enrollment in Medicare, the contractor for that State may not deny the supplier's enrollment application solely on the grounds that the supplier does not have a practice location in that State. (This policy only applies to air ambulance suppliers.)

9. Paramedic Intercept Information

Paramedic intercept services typically involves an arrangement between a basic life support (BLS) ambulance supplier and an advanced life support (ALS) ambulance supplier, whereby the latter provides the ALS services and the BLS supplier provides the transportation component. (See 42 CFR § 410.40 for more information.) If the applicant indicates that it has such an arrangement, it must attach a copy of the agreement/contract.

10. Air Ambulances

Air ambulance suppliers must submit the following:

Proof that the air ambulance supplier or its leasing company possesses a valid charter flight license (FAA Part 135 Certificate) for the aircraft being used as an air ambulance. Any of the following constitutes acceptable proof:

- If the air ambulance supplier or provider owns the aircraft, the owner's name on the FAA Part 135 certificate must be the same as the supplier's or provider's name on the enrollment application.
- If the air ambulance supplier or provider owns the aircraft but contracts with an air services vendor to supply pilots, training and/or vehicle maintenance, the FAA Part 135 certificate must be issued in the name of the air services vendor. A certification from the supplier or provider must also attest that it has an agreement with the air services vendor and must list the date of that agreement. A copy of the FAA Part 135 Certificate must accompany the enrollment application.
- If the air ambulance supplier or provider leases the aircraft from another entity, a copy of the lease agreement must accompany the enrollment application. The name of the company leasing the aircraft from that other entity must be the same as the supplier's or provider's name on the enrollment application.

The air ambulance supplier shall maintain all applicable Federal and State licenses and certifications, including pilot certifications, instrument and medical certifications and air worthiness certifications.

In addition:

- The contractor shall access the following FAA Web site on a quarterly basis to validate all licenses/certifications of air ambulance operators that are enrolled with the contractor:
https://www.faa.gov/about/office_org/headquarters_offices/agc/practice_areas/enforcement/reports/
- The contractor shall deny or revoke the enrollment of an air ambulance supplier if the supplier does not maintain its FAA certification or any other applicable licenses.

11. Hospital-Based Ambulances

An ambulance service that is owned and operated by a hospital need not complete a Form CMS-855B if:

- The ambulance services will appear on the hospital's cost-report; and
- The hospital possesses all licenses required by the State or locality to operate the ambulance service.

If the hospital decides to divest itself of the ambulance service, the latter will have to complete a Form CMS-855B if it wishes to bill Medicare.

H. Intensive Cardiac Rehabilitation (ICR)

ICR suppliers are a supplier type that enrolls via the Form CMS-855B.

1. Background

ICR programs must be approved by CMS through the national coverage determination (NCD) process and must meet certain criteria for approval. Individual sites seeking to provide ICR services via an approved ICR program must enroll with their local Medicare contractor as an ICR program supplier.

2. ICR Enrollment

In order to enroll as an Intensive Cardiac Rehab (ICR) site, a supplier must complete a Form CMS-855B, with the supplier type of "Intensive Cardiac Rehabilitation" selected. The contractor shall verify that CMS has approved the ICR program through the NCD process. A list of approved ICR programs will be identified through the NCD listings, the CMS Web site and the Federal Register. The contractor shall use one of these options to verify that the ICR program has met CMS approval.

An ICR supplier must separately and individually enroll each of its practice locations. The supplier can therefore only have one practice location – which shall receive its own Provider Transaction Access Number - on its Form CMS-855B enrollment application.

The contractor shall use specialty code 31 for these enrollments.

The contractor shall only accept and process reassignments (Form CMS-855Rs) to ICR suppliers from physicians defined in section 1861(r)(1) of the Social Security Act. However, reassignments are not required.

It is important that the contractor review and adhere to the following regulations and instructions regarding the required qualifications of ICR suppliers:

- 42 CFR § 410.49
- Publication 100-04, Medicare Claims Processing Manual, chapter 32, sections 140.2.2 – 140.2.2.6
- Publication 100-02, Medicare Benefit Policy Manual, chapter 15, section 232

I. Independent Diagnostic Testing Facilities (IDTFs)

IDTFs are a supplier type that enroll via the Form CMS-855B.

1. General Background Information

An IDTF is a facility that is independent both of an attending or consulting physician's office and of a hospital. However, IDTF general coverage and payment policy rules apply when an IDTF furnishes diagnostic procedures in a physician's office (see 42 Code of Federal Regulations (CFR) 410.33(a)(1)).

Effective for diagnostic procedures performed on or after March 15, 1999, MACs pay for diagnostic procedures under the physician fee schedule when performed by an IDTF. An IDTF may be a fixed location or a mobile entity. It is independent of a physician's office or hospital.

2. IDTF Standards

Consistent with 42 CFR §410.33(g), each IDTF must certify on its Form CMS-855B enrollment application that it meets the following standards and all other requirements:

- a. Operates its business in compliance with all applicable Federal and State licensure and regulatory requirements for the health and safety of patients.
- The purpose of this standard is to ensure that suppliers are licensed in the business and specialties being provided to Medicare beneficiaries. Licenses are required by State and/or Federal agencies to make certain that guidelines and regulations are being followed and to ensure that businesses are furnishing quality services to Medicare beneficiaries.
 - The responsibility for determining what licenses are required to operate a supplier's business is the sole responsibility of the supplier. The contractor is not responsible for notifying any supplier of what licenses are required or that any changes have occurred in the licensure

requirements. No exemptions to applicable State licensing requirements are permitted, except when granted by the State.

- The contractor shall not grant billing privileges to any business not appropriately licensed as required by the appropriate State or Federal agency. If a supplier is found providing services for which it is not properly licensed, billing privileges may be revoked and appropriate recoupment actions taken.

b. Provides complete and accurate information on its enrollment application. Changes in ownership, changes of location, changes in general supervision, and final adverse actions must be reported to the contractor within 30 calendar days of the change. All other changes to the enrollment application must be reported within 90 days.

NOTE: This 30-day requirement takes precedence over the certification in section 15 of the Form CMS-855B whereby the supplier agrees to notify Medicare of any changes to its enrollment data within 90 days of the effective date of the change. By signing the certification statement, the IDTF agrees to abide by all Medicare rules for its supplier type, including the 30-day rule in 42 CFR §410.33(g)(2).

c. Maintain a physical facility on an appropriate site. (For purposes of this standard, a post office box, commercial mailbox, hotel, or motel is not an appropriate site. The physical facility, including mobile units, must contain space for equipment appropriate to the services designated on the enrollment application, facilities for hand washing, adequate patient privacy accommodations, and the storage of both business records and current medical records within the office setting of the IDTF, or IDTF home office, not within the actual mobile unit.)

- IDTF suppliers that provide services remotely and do not see beneficiaries at their practice location are exempt from providing hand washing and adequate patient privacy accommodations.
- The requirements in 42 CFR §410.33(g)(3) take precedence over the guidelines in Section 10.3.1(B)(1)(d) of this chapter pertaining to the supplier's practice location requirements.
- The physical location must have an address, including the suite identifier, which is recognized by the United States Postal Service (USPS).

d. Has all applicable diagnostic testing equipment available at the physical site excluding portable diagnostic testing equipment. The IDTF must—

(i) Maintain a catalog of portable diagnostic equipment, including diagnostic testing equipment serial numbers, at the physical site;

(ii) Make portable diagnostic testing equipment available for inspection within 2 business days of a CMS inspection request; and

(iii) Maintain a current inventory of the diagnostic testing equipment, including serial and registration numbers, and provide this information to the designated fee-for-service contractor upon request, and notify the contractor of any changes in equipment within 90 days.

e. Maintain a primary business phone under the name of the designated business. The IDTF must have its –

(i) Primary business phone located at the designated site of the business or within the home office of the mobile IDTF units.

(ii) Telephone or toll free telephone numbers available in a local directory and through directory assistance.

The requirements in 42 CFR §410.33(g)(5) take precedence over the guidelines in Section 10.3.1(B)(1)(d) of this chapter regarding the supplier's telephone requirements.

IDTFs may not use “call forwarding” or an answering service as their primary method of receiving calls from beneficiaries during posted operating hours.

f. Have a comprehensive liability insurance policy of at least \$300,000 per location that covers both the place of business and all customers and employees of the IDTF. The policy must be carried by a non-relative-owned company. Failure to maintain required insurance at all times will result in revocation of the IDTF's billing privileges retroactive to the date the insurance lapsed. IDTF suppliers are responsible for providing the contact information for the issuing insurance agent and the underwriter. In addition, the IDTF must--

(i) Ensure that the insurance policy must remain in force at all times and provide coverage of at least \$300,000 per incident; and

(ii) Notify the CMS designated contractor in writing of any policy changes or cancellations.

g. Agree not to directly solicit patients; this includes - but is not limited to - a prohibition on telephone, computer, or in-person contacts. The IDTF must accept only those patients referred for diagnostic testing by an attending physician who: (a) is furnishing a consultation or treating a beneficiary for a specific medical problem, and (2) uses the results in the management of the beneficiary's specific medical problem. Non-physician practitioners may order tests as set forth in §410.32(a)(3).

- By the signature of the authorized official in section 15 of the Form CMS-855B, the IDTF agrees to comply with 42 CFR §410.33(g)(7).
- The supplier is prohibited from directly contacting any individual beneficiary for the purpose of soliciting business for the IDTF. This includes contacting the individual beneficiary by telephone or via door-to-door sales.

- There is no prohibition on television, radio or Internet advertisements, mass mailings, or similar efforts to attract potential clients to an IDTF.

h. Answer, document, and maintain documentation of a beneficiary's written clinical complaint at the physical site of the IDTF. (For mobile IDTFs, this documentation would be stored at their home office.) This includes, but is not limited to, the following:

(i) The name, address, telephone number, and health insurance claim number of the beneficiary.

(ii) The date the complaint was received; the name of the person receiving the complaint; and a summary of actions taken to resolve the complaint.

(iii) If an investigation was not conducted, the name of the person making the decision and the reason for the decision.

i. Openly post these standards for review by patients and the public.

j. Disclose to the government any person having ownership, financial, or control interest or any other legal interest in the supplier at the time of enrollment or within 30 days of a change.

k. Have its testing equipment calibrated and maintained per equipment instructions and in compliance with applicable manufacturers' suggested maintenance and calibration standards.

l. Have technical staff on duty with the appropriate credentials to perform tests. The IDTF must be able to produce the applicable Federal or State licenses or certifications of the individuals performing these services.

m. Have proper medical record storage and be able to retrieve medical records upon request from CMS or its fee-for-service contractor within 2 business days.

n. Permit CMS, including its agents, or its designated fee-for-service contractors, to conduct unannounced, on-site inspections to confirm the IDTF's compliance with these standards. The IDTF must---

(i) Be accessible during regular business hours to CMS and beneficiaries; and

(ii) Maintain a visible sign posting its normal business hours.

o. Enrolls in Medicare for any diagnostic testing services that it furnishes to a Medicare beneficiary, regardless of whether the service is furnished in a mobile or fixed-base location.

p. Bills for all mobile diagnostic services that are furnished to a Medicare beneficiary, unless the mobile diagnostic service is part of a service provided

under arrangement as described in section 1861(w)(1) of the Act. (Section 1861(w)(1) states that the term “arrangements” is limited to arrangements under which receipt of payments by the hospital, critical access hospital, skilled nursing facility, home health agency or hospice program (whether in its own right or as an agent), with respect to services for which an individual is entitled to have payment made under this title, discharges the liability of such individual or any other person to pay for the services.)

If the IDTF claims that it is furnishing services under arrangement as described in section 1861(w)(1), the IDTF must provide documentation of such with its initial or revalidation Form CMS-855 application.

The IDTF must meet all of the standards in 42 CFR §410.33 – as well as all other Federal and State statutory and regulatory requirements – in order to be enrolled in, and to maintain its enrollment in, the Medicare program. Failure to meet any of the standards in 42 CFR §410.33 or any other applicable requirements will result in the denial of the supplier’s Form CMS-855 application or, if the supplier is already enrolled in Medicare, the revocation of its Medicare billing privileges.

3. Leasing and Staffing

For purposes of the provisions in 42 CFR §410.33, a "mobile IDTF" does not include entities that lease or contract with a Medicare enrolled provider or supplier to provide: (1) diagnostic testing equipment; (2) non-physician personnel described in 42 CFR §410.33(c); or (3) diagnostic testing equipment and non-physician personnel described in 42 CFR §410.33(c). This is because the provider/supplier is responsible for providing the appropriate level of physician supervision for the diagnostic testing.

An IDTF is not required to report equipment that the IDTF is leasing for a period less than 90 days, unless the IDTF is leasing equipment for services that they have not already reported on a CMS-855B IDTF Attachment. For all new services being provided, IDTFs would need to complete a change of information to include the equipment and CPT/HCPCS codes that will be billed. Any accreditation for the services provided would need to be obtained by the IDTF.

4. Sharing of Space and Equipment

Effective January 1, 2008, with the exception of hospital-based and mobile IDTFs, a fixed-base IDTF does not: (i) share a practice location with another Medicare-enrolled individual or organization; (ii) lease or sublease its operations or its practice location to another Medicare-enrolled individual or organization; or (iii) share diagnostic testing equipment used in the initial diagnostic test with another Medicare-enrolled individual or organization. (See 42 CFR §410.33(g)(15).)

If the contractor determines that an IDTF is leasing or subleasing its operations to another organization or individual, the contractor shall revoke the supplier’s Medicare billing privileges.

5. Multi-State IDTFs

As stated in 42 CFR § 410.33(e)(1), an IDTF that operates across State boundaries must:

- a. Maintain documentation that its supervising physicians and technicians are licensed and certified in each of the States in which it operates; and
- b. Operate in compliance with all applicable Federal, State, and local licensure and regulatory requirements with regard to the health and safety of patients.

The point of the actual delivery of service means the place of service on the claim form. When the IDTF performs or administers an entire diagnostic test at the beneficiary's location, the beneficiary's location is the place of service. When one or more aspects of the diagnostic testing are performed at the IDTF, the IDTF is the place of service.

6. IDTF Enrollment Information

Consistent with 42 CFR §410.33(g), each IDTF must certify on its Form CMS-855B enrollment application that it meets the IDTF standards under Section 10.2.2(I)(2) of this Chapter and all other requirements.

7. One Enrollment per Practice Location

An IDTF must separately enroll each of its practice locations (with the exception of locations that are used solely as warehouses or repair facilities). This means that an enrolling IDTF can only have one practice location on its Form CMS-855B enrollment application; thus, if an IDTF is adding a practice location to its existing enrollment, it must submit a new, complete Form CMS-855B application for that location and have that location undergo a separate site visit. Also, each of the IDTF's mobile units must enroll separately. Consequently, if a fixed IDTF site also contains a mobile unit, the mobile unit must enroll separately from the fixed location.

Each separately enrolled practice location of the IDTF must meet all applicable IDTF requirements. The location's failure to comply with any of these requirements will result in the revocation of its Medicare billing privileges.

If an IDTF adds equipment for diagnostic testing that is mobile in nature, but is fixed permanently to the IDTF's physical location (i.e.: a CT scanner that is mounted in a bus or trailer, but is parked at the IDTF's site for use by the IDTF), a second enrollment is not necessary. This equipment can be listed in the Form CMS-855B along with the services performed on the equipment. In these cases, the MAC shall indicate the use of a fixed mobile unit is in use at the IDTF's site in the site visit request so the site inspector will know to view the fixed mobile equipment as part of the IDTF.

8. Interpreting Physicians

a. Listing Interpreting Physicians

The applicant shall list all physicians for whose diagnostic test interpretations it will bill. This includes physicians who will provide interpretations subject to the anti-markup payment limitation as detailed in CMS Publication 100-04, chapter 1, § 30.2.9 - whether the service is provided to the IDTF on a contract basis or is reassigned.

The contractor shall ensure and document that:

- All listed physicians are enrolled in Medicare
- All interpreting physicians who are reassigning their benefits to the IDTF have the right to do so
- The interpreting physicians listed are qualified to interpret the types of tests (codes) listed. (The contractor may need to contact another contractor to obtain this information.) If the applicant does not list any interpreting physicians, the contractor need not request additional information because the applicant may not be billing for the interpretations; that is, the physicians may be billing for the interpretation themselves.

If an interpreting physician has been recently added or changed, the new interpreting physician must have met all of the interpreting physician requirements at the time any tests were performed.

A Form CMS-855R need not accompany a Form CMS-855B application submitted by an independent diagnostic testing facility (IDTF) that employs or contracts with an interpreting physician.

b. Changes of Interpreting Physicians

If an interpreting physician is being added or changed, the updated information must be reported via a Form CMS-855B change request. The new interpreting physician must have met all of the necessary requirements at the time any tests were performed to perform services as an interpreting physician.

If the contractor receives notification from an interpreting physician that he/she is no longer interpreting tests at the IDTF, the contractor shall request from the supplier a Form CMS-855B change of information to end date the interpreting physician from the enrollment.

9. Effective Date of IDTF Billing Privileges

The filing date of an IDTF Medicare enrollment application is the date that the contractor receives a signed application that it is able to process to approval. (See 42 CFR §410.33(i).) The effective date of billing privileges for a newly enrolled IDTF is the later of the following:

(1) The filing date of the Medicare enrollment application that was subsequently approved by a MAC; or

(2) The date the IDTF first started furnishing services at its new practice location.

A newly-enrolled IDTF, therefore, may not receive reimbursement for services furnished before the effective date of billing privileges.

The contractor shall note that if it rejects an IDTF application and a new application is later submitted, the date of filing is the date the contractor receives the new enrollment application.

If an IDTF undergoes an ownership change that results in a new enrollment in PECOS (a new federal Tax Identification Number is a result of this change), MACs should use the transfer of ownership/business date as indicated by the IDTF, instead of establishing a new effective date.

10. IDTF Technicians Must be Listed on the Form CMS-855B

Each non-physician who performs IDTF diagnostic tests must be listed. These persons are often referred to as technicians.

11. IDTF Technicians Licensure and Certification Requirements

All technicians must meet the standards of a state license or state certification at the time of the IDTF's enrollment. The contractor may not grant temporary exemptions from such requirements.

In lieu of requiring a copy of the technician's certification card, the contractor may validate a technician's credentials online via organizations such as the American Registry for Diagnostic Medical Sonography (ARDMS), the American Registry of Radiology Technologists (ARRT), and the Nuclear Medicine Technology Certification Board (NMTCB). If online verification is not available or cannot be made, the contractor shall request a copy of the technician's certification card.

12. IDTF: Changes of Technicians

If a technician is being added or changed, the updated information must be reported via a Form CMS-855B change request. The new technician must have met all of the necessary credentialing requirements at the time any tests were performed.

If the contractor receives notification from a technician that he/she is no longer performing tests at the IDTF, the contractor shall request from the supplier a Form CMS-855B change of information. If the provider did not have another technician qualified to perform the tests listed on the current application, the supplier must submit significant documentation in the form of payroll records, etc. to substantiate the performance of the test by a properly qualified technician after the date the original technician was no longer performing procedures at the IDTF.

13. IDTF Supervising Physicians – General Principles

Under 42 CFR §410.33(b)(1), an independent diagnostic testing facility (IDTF) must have one or more supervising physicians who are responsible for:

- The direct and ongoing oversight of the quality of the testing performed;
- The proper operation and calibration of equipment used to perform tests; and
- The qualifications of non-physician IDTF personnel who use the equipment.

Not every supervising physician has to be responsible for all of these functions. For instance, one supervising physician can be responsible for the operation and calibration of equipment, while another supervising physician can be responsible for test supervision and the qualifications of non-physician personnel. The basic requirement, however, is that all supervising physician functions must be properly met at each location, regardless of the number of physicians involved. This is particularly applicable to mobile IDTF units that are allowed to use different supervising physicians at different locations. They may have a different physician supervise the test at each location. The physicians used need only meet the proficiency standards for the tests they are supervising.

Under 42 CFR §410.33(b)(1), each supervising physician must be limited to providing general supervision at no more than three IDTF sites. This applies to both fixed sites and mobile units where three concurrent operations are capable of performing tests.

14. IDTF: Information about Supervising Physicians

The contractor shall ensure and document that each supervising physician is: (1) licensed to practice in the State(s) where the diagnostic tests he or she supervises will be performed, (2) Medicare-enrolled, and (3) not currently excluded or debarred. The physician(s) need not necessarily be Medicare-enrolled in the State where the IDTF is enrolled; moreover, the physician need not be furnishing medical services outside of his/her role as a supervising physician (i.e., he/she need not have his/her own medical practice separate from the IDTF). If the physician is enrolled in another State or with another contractor, however, the contractor shall ensure that he or she is appropriately licensed in that State.

In addition:

- Each physician of the group who actually performs an IDTF supervisory function must be listed.
- If a supervising physician has been recently added or changed, the updated information must be reported via a Form CMS-855B change request. The

new physician must have met all of the supervising physician requirements at the time any tests were performed.

- If the contractor knows that a listed supervising physician has been listed with several other IDTFs, the contractor shall check with the physician to determine whether he or she is still acting as supervising physician for these other IDTFs.
- If the supervising physician is enrolling in Medicare and does not intend to perform medical services outside of his/her role as a supervising physician:
 - The contractor shall still send the physician an approval letter (assuming successful enrollment) and issue a Provider Transaction Access Number
 - The physician shall list the IDTF's address as a practice location
 - The space-sharing prohibition in 42 CFR §410.33(g) does not apply in this particular scenario.

IDTF: General, Direct, and Personal Supervision

Under 42 CFR §410.33(b)(2), if a procedure requires the direct or personal supervision of a physician as set forth in 42 CFR §410.32(b)(3), the contractor shall ensure that the IDTF's supervising physician furnishes this level of supervision.

The contractor's enrollment staff shall be familiar with the definitions of personal, direct and general supervision set forth at 42 CFR §410.32(b)(3), and shall ensure that the applicant has checked the highest required level of supervision for the tests being performed.

Each box that begins with "Assumes responsibility," must be checked. However, as indicated previously, the boxes can be checked through the use of more than one physician.

IDTF: Attestation Statement for Supervising Physicians

A separate attestation statement must be completed and signed by each supervising physician listed. If Question E2 is not completed, the contractor may assume – unless it has reason to suspect otherwise - that the supervising physician in question supervises for all codes listed in section 2 of the IDTF attachment. If Question E2 is completed, the contractor shall ensure that all codes listed in section 2 are covered through the use of multiple supervising physicians.

With respect to physician verification, the contractor shall contact each supervisory physician by telephone to verify that the physician: (1) actually exists (e.g., is not using a phony or inactive physician number); (2) indeed signed the attestation; and (3) is aware of his or her responsibilities.

If the physician is enrolled with a different contractor, the contractor shall contact the latter contractor and obtain the listed telephone number of the physician.

IDTF: Changes of Supervising Physicians

If a supervising physician is being added or changed, the updated information must be reported via a Form CMS-855B change request. The new supervising physician must have met all of the necessary requirements at the time any tests were performed to perform services as a supervising physician.

If the contractor receives notification from a supervising physician that he/she is no longer supervising tests at the IDTF, the contractor shall request from the supplier a Form CMS-855B change of information. If the IDTF did not have another supervising physician listed on the current application, the IDTF must submit a change of information adding a new supervising physician. If the IDTF does not provide this information, the MAC shall proceed with non-compliance revocation procedures as noted in Section 10.4(M) of this chapter.

15. Desk and Site Reviews

All initial and revalidating independent diagnostic testing facility (IDTF) applicants shall receive: (1) a thorough desk review, and (2) a mandatory site visit prior to the contractor's approval of the application. The general purposes of these reviews are to determine whether:

- The information listed on Attachment 2 of the Form CMS-855B is correct, verifiable, and in accordance with all IDTF regulatory and enrollment requirements.
- To the extent applicable, the IDTF meets the criteria outlined in Section 10.6.20(A) and 10.6.20(B) of this chapter.
- The IDTF meets the supplier standards in 42 CFR § 410.33.

The contractor shall order the site visit through the Provider Enrollment, Chain and Ownership System. The National Site Visit Contractor (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.

16. Mobile Units

Mobile units are required to list their geographic service areas in section 4 of the Form CMS-855B. Based on the information furnished therein, the NSVC will generally perform the site visit via one of the following methods: (1) the mobile unit visits the office of the NSVC (or some other agreed-to location) for inspection, (2) the NSVC visits the mobile unit's base of operations to inspect the unit, or (3) the NSVC obtains an advance schedule of the locations at which the IDTF will be performing services and conducts the site visit at one of those locations.

Units that are performing CPT-4 or HCPCS code procedures that require direct or personal supervision mandate special attention. To this end, the contractor shall maintain a listing of all mobile IDTFs that perform procedure codes that require such levels of supervision. The contractor shall also discuss with the applicant and all supervising physicians listed:

- How they will perform these types of supervision on a mobile basis;
- What their responsibilities are; and
- That a patient's physician who is performing direct or personal supervision for the IDTF on their patient should be aware of the prohibition concerning physician self-referral for testing (in particular, this concerns potentially illegal compensation to the supervisory physician from the IDTF).

17. Addition of Codes

An enrolled IDTF that wants to perform additional CPT-4 or HCPCS codes must submit a Form CMS-855B change request. If the additional procedures are of a type and supervision level similar to those previously reported (e.g., an IDTF that performs MRIs for shoulders wants to perform MRIs for hips), a new site visit is typically not required, though the contractor reserves the right to request that the NSVC perform one.

If, however, the enrolled IDTF wants to perform additional procedures that are not similar to those previously reported (e.g., an IDTF that conducts sleep studies wants to perform ultrasound tests or skeletal x-rays), the contractor shall order an NSVC site visit through PECOS. All IDTF claims for the additional procedures shall be suspended until the IDTF: (1) passes all enrollment requirements for the additional procedures (e.g., supervisory physician, non-physician personnel, equipment), and (2) presents evidence that all requirements for the new procedures were met when the tests were actually performed.

If the enrolled IDTF originally listed only general supervision codes, was only reviewed for only general supervision tests, and now wants to perform tests that require direct or personal supervision, the contractor shall promptly suspend all payments for all codes other than those requiring general supervision. The contractor shall order an NSVC site visit through PECOS. All IDTF claims for the additional procedures shall be suspended until the IDTF: (1) passes all enrollment requirements for the additional procedures (e.g., supervisory physician, non-physician personnel, equipment), and (2) presents evidence that all requirements for the new procedures were met when the tests were actually performed.

In the situations described in the two previous paragraphs, the contractor shall not approve the application prior to the completion of the NSVC's site visit and the contractor's review of the results.

18. IDTF That Performs Diagnostic Mammography

If an independent diagnostic testing facility (IDTF) performs diagnostic mammography services, it must have a Food and Drug Administration (FDA) certification to perform the mammography. However, an entity that only performs diagnostic mammography services should not be enrolled as an IDTF. Rather, it should be separately enrolled as a mammography screening center.

19. IDTF Ownership of CLIA Laboratory

An IDTF may not perform or bill for CLIA tests. However, an entity with one tax identification number (TIN) may own both an IDTF and an independent CLIA laboratory. In such a situation, they should be separately enrolled and advised to bill separately. The contractor shall also advise its claims unit to ensure that the CLIA codes are not being billed under the IDTF provider number.

10.2.3 - Individual Practitioners That Enroll Via the Form CMS-855I

(Rev. 10611; Issued: 03-19-21; Effective:11-19-20; Implementation: 11-19-20)

This section provides background information on physicians and non-physician practitioners (NPPs). While Medicare has established Federal standards governing these supplier types, these practitioners must also comply with all applicable state and local laws as a precondition of enrollment.

It is important that contractors review Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15 for specific information regarding the required qualifications of the suppliers listed in this section 10.2.3 et seq.

A. Anesthesiology Assistants

Federal regulations at 42 CFR § 410.69(b) defines an anesthesiology assistant as a person who:

1. Works under the direction of an anesthesiologist;
2. Is in compliance with all applicable requirements of state law, including any licensure requirements the state imposes on non-physician anesthesiologists; and
3. Is a graduate of a medical school-based anesthesiologist's assistant educational program that:
 - Is accredited by the Committee on Allied Health Education and Accreditation; and
 - Includes approximately 2 years of specialized basic science and clinical education in anesthesia at a level that builds on a premedical undergraduate science background.

With respect to education and training, Pub. 100-04, Medicare Claims Processing Manual, Chapter 12, section 140.1 further describes an anesthesiology assistant as a person who has successfully completed a 6-year program for anesthesiology assistants, of which 2 years consists of specialized academic and clinical training in anesthesia.

B. Audiologists

Section 1861(l)(3)(B) of the Social Security Act and Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, section 80.3.1 state that a qualified audiologist means an individual with a master's or doctoral degree in audiology who:

1. Is licensed as an audiologist by the state in which the individual furnishes such services; or
2. In the case of an individual who furnishes services in a state which does not license audiologists, has:
 - Successfully completed 350 clock hours of supervised clinical practicum (or is in the process of accumulating such supervised clinical experience), and
 - Performed not less than 9 months of supervised full-time audiology services after obtaining a master's or doctoral degree in audiology or a related field, and
 - Successfully completed a national examination in audiology approved by the Secretary.

C. Certified Nurse-Midwives

Federal regulations at 42 CFR §410.77 list the Medicare qualifications for certified nurse-midwives (CNMs). These qualifications require that a CNM must:

- Be a registered nurse who is legally authorized to practice as a nurse-midwife in the state where services are performed;
- Have successfully completed a program of study and clinical experience for nurse-midwives that is accredited by an accrediting body approved by the U.S. Department of Education; and
- Be certified as a nurse-midwife by the American College of Nurse-Midwives or the American College of Nurse-Midwives Certification Council.

For more information on certified nurse midwives, refer to:

- Section 1861(gg) of the Social Security Act;
- Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, section 180; and

- Pub. 100-04, Medicare Claims Processing Manual, Chapter 12, section 130.1.

D. Certified Registered Nurse Anesthetists (CRNAs)

Federal regulations at 42 CFR § 410.69(b) state that a CRNA is a registered nurse who:

1. Is licensed as a registered professional nurse by the state in which the nurse practices;
2. Meets any licensure requirements the state imposes with respect to non-physician anesthetists;
3. Has graduated from a nurse anesthesia educational program that meets the standards of the Council on Accreditation of Nurse Anesthesia Programs, or such other accreditation organization as may be designated by the Secretary; and
4. Meets the following criteria:
 - a. Has passed a certification examination of the Council on Certification of Nurse Anesthetists, the Council on Recertification of Nurse Anesthetists, or any other certification organization that may be designated by the Secretary; or
 - b. Is a graduate of a program described in paragraph (3) and within 24 months after that graduation meets the requirements of paragraph (4)(i).

For more information on CRNAs, refer to:

- Section 1861(bb) of the Social Security Act
- Pub. 100-04, Medicare Claims Processing Manual, Chapter 12, section 140.1

E. Clinical Nurse Specialists

Federal regulations at 42 CFR §410.76 and in Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, section 210 states that a clinical nurse specialist must meet all of the following requirements:

1. Be a registered nurse who is currently licensed to practice in the state where he or she practices and be authorized to furnish the services of a clinical nurse specialist in accordance with state law.
2. Have a master's degree in a defined clinical area of nursing from an accredited educational institution or a Doctor of Nursing Practice (DNP) doctoral degree; and

3. Be certified as a clinical nurse specialist by a recognized national certifying body that has established standards for clinical nurse specialists and that is approved by the Secretary.

Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, section 210 states that the following organizations are recognized by CMS as national certifying bodies for clinical nurse specialists at the advanced practice level:

- a. American Academy of Nurse Practitioners;
- b. American Nurses Credentialing Center;
- c. National Certification Corporation for Obstetric, Gynecologic and Neonatal Nursing Specialties;
- d. Pediatric Nursing Certification Board (previously named the National Certification Board of Pediatric Nurse Practitioners and Nurses);
- e. Oncology Nurses Certification Corporation;
- f. AACN Certification Corporation; and
- g. National Board on Certification of Hospice and Palliative Nurses.

F. Clinical Psychologists

Federal regulations at 42 CFR § 410.71(d) state that to qualify as a clinical psychologist, a practitioner must meet the following requirements:

- 1. Hold a doctoral degree in psychology (that is, a Ph.D., Ed.D., Psy.D.), and
- 2. Is licensed or certified, on the basis of the doctoral degree in psychology, by the state in which he or she practices, at the independent practice level of psychology, to furnish diagnostic, assessment, preventive, and therapeutic services directly to individuals.

Clinical psychologists are authorized under the Medicare program to furnish “physician” services that fall under their state scope of practice and, have services furnished as an incident to their own personal professional services without physician supervision, involvement or oversight. Clinical psychologists can perform diagnostic psychological and neuropsychological tests without a physician or authorized non-physician practitioner’s order. Solely for purposes of diagnostic psychological and neuropsychological tests, clinical psychologists are authorized to supervise these tests in addition to physicians.

A clinical psychologist must agree to meet the consultation requirements of 42 CFR §410.71(e)(1) through (e)(3). Under 42 CFR § 410.71(e), the practitioner’s signing of the Form CMS-855I indicates his or her agreement to attempt to consult with their patient’s primary care or attending physician.

For more information on clinical psychologists, refer to Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, section 160.

G. Clinical Social Workers

Federal regulations at 42 CFR §410.73(a) defines a clinical social worker as an individual who:

1. Possesses a master's or doctor's degree in social work;
2. After obtaining the degree, has performed at least 2 years of supervised clinical social work; and
3. Either is licensed or certified as a clinical social worker by the state in which the services are performed or, in the case of an individual in a state that does not provide for licensure or certification as a clinical social worker—
 - a. Is licensed or certified at the highest level of practice provided by the laws of the state in which the services are performed; and
 - b. Has completed at least 2 years or 3,000 hours of post master's degree supervised clinical social work practice under the supervision of a master's degree level social worker in an appropriate setting, such as a hospital, SNF, or clinic.

For more information on clinical social workers, refer to Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, section 170.

H. Nurse Practitioners

Federal regulations at 42 CFR § 410.75(b) state that a nurse practitioner must be a registered professional nurse who is authorized by the state in which the services are furnished to practice as a nurse practitioner in accordance with state law. The individual must also meet one of the following criteria:

1. Obtained Medicare billing privileges as a nurse practitioner for the first time on or after January 1, 2003, and meets the following requirements:
 - a. Is certified as a nurse practitioner by a recognized national certifying body that has established standards for nurse practitioners.
 - b. Possesses a master's degree in nursing or a Doctor of Nursing Practice (DNP) doctoral degree.
 - If the master's or doctoral degree is required to obtain a license as an NP in the state, then the MACs do not need to separately verify the degree or require documentation be submitted by the provider.
2. Obtained Medicare billing privileges as a nurse practitioner for the first time before January 1, 2003, and -meets the standards in (1)(a) above.
3. Obtained Medicare billing privileges as a nurse practitioner for the first time before January 1, 2001.

Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, section 200 lists the following organizations as CMS-recognized national certifying bodies for nurse practitioners at the advanced practice level:

- American Academy of Nurse Practitioners;
- American Nurses Credentialing Center;
- National Certification Corporation for Obstetric, Gynecologic and Neonatal Nursing Specialties;
- Pediatric Nursing Certification Board (previously named the National Certification Board of Pediatric Nurse Practitioners and Nurses);
- Oncology Nurses Certification Corporation;
- AACN Certification Corporation; and
- National Board on Certification of Hospice and Palliative Nurses

I. Occupational Therapists in Private Practice

1. Private Practice

Section 42 CFR 410.59(c)(ii), (iii), and (iv) state that an occupational therapist in private practice must:

- a. Engage in the private practice of occupational therapy on a regular basis as an individual, in one of the following practice types:
 - i. An unincorporated solo practice.
 - ii. A partnership or unincorporated group practice.
 - iii. An unincorporated solo practice, partnership, or group practice, or a professional corporation or other incorporated occupational therapy practice.
 - iv. An employee of a physician group.
 - v. An employee of a group that is not a professional corporation.

AND

- b. Bill Medicare only for services furnished in his or her private practice office space, or in the patient's home.
 - i. A therapist's private practice office space refers to the location(s) where the practice is operated, in the state(s) where the therapist (and practice, if applicable) is legally authorized to furnish services, during the hours that the therapist engages in practice at that location. When services are furnished in private practice office space, such space must be owned, leased, or rented by the practice and used for the exclusive purpose of operating the practice.

- ii. A patient's home does not include any institution that is a hospital, a CAH, or a SNF.

AND

- c. Treat individuals who are patients of the practice and for whom the practice collects fees for the services furnished.

2. Regulatory Definition

Section 42 CFR § 484.4 defines an occupational therapist as an individual who:

- (a) Is licensed or otherwise regulated, if applicable, as an occupational therapist by the state in which practicing, unless licensure does not apply;
- (b) Graduated after successful completion of an occupational therapist education program accredited by the Accreditation Council for Occupational Therapy Education (ACOTE) of the American Occupational Therapy Association, Inc. (AOTA), or successor organizations of ACOTE; and
- (c) Is eligible to take, or has successfully completed the entry-level certification examination for occupational therapists developed and administered by the National Board for Certification in Occupational Therapy, Inc. (NBCOT).

OR

On or before December 31, 2009--

- (a) Is licensed or otherwise regulated, if applicable, as an occupational therapist by the state in which practicing; or
- (b) When licensure or other regulation does not apply--
 - (i) Graduated after successful completion of an occupational therapist education program accredited by the Accreditation Council for Occupational Therapy Education (ACOTE) of the American Occupational Therapy Association, Inc. (AOTA) or successor organizations of ACOTE; and
 - (ii) Is eligible to take, or has successfully completed the entry-level certification examination for occupational therapists developed and administered by the National Board for Certification in Occupational Therapy, Inc., (NBCOT).

OR

On or before January 1, 2008--

- (a) Graduated after successful completion of an occupational therapy program accredited jointly by the committee on Allied Health Education and

Accreditation of the American Medical Association and the American Occupational Therapy Association; or

(b) Is eligible for the National Registration Examination of the American Occupational Therapy Association or the National Board for Certification in Occupational Therapy.

OR

On or before December 31, 1977--

(a) Had 2 years of appropriate experience as an occupational therapist; and

(b) Had achieved a satisfactory grade on an occupational therapist proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service.

3. Occupational Therapist Educated Outside the United States

Section 42 CFR § 484.4 states that if the occupational therapist was educated outside the United States, he or she must meet all of the following:

a. Graduated after successful completion of an occupational therapist education program accredited as substantially equivalent to occupational therapist entry-level education in the United States by one of the following:

(i) The Accreditation Council for Occupational Therapy Education (ACOTE).

(ii) Successor organizations of ACOTE.

(iii) The World Federation of Occupational Therapists.

(iv) A credentialing body approved by the American Occupational Therapy Association.

b. Successfully completed the entry-level certification examination for occupational therapists developed and administered by the National Board for Certification in Occupational Therapy, Inc. (NBCOT).

c. On or before December 31, 2009, is licensed or otherwise regulated, if applicable, as an occupational therapist by the state in which practicing.

4. Occupational Therapists: Additional References

See Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15:

- Section 230.2(B) for more detailed information regarding the required qualifications of occupational therapists.
- Section 230.4 for detailed information regarding the term “private practice.”

5. Other Enrollment Information

All OTs in private practice must respond to the questions in section 2K of the CMS-855I. If the OT plans to provide his/her services as: (1) a member of an established OT group, (2) an employee of a physician-directed group, or (3) an employee of a non-professional corporation, and that person wishes to reassign his/her benefits to that group, this section does not apply.

If the OT checks that he/she renders all of his/her services in patients' homes, the contractor shall verify that he/she has an established private practice where he/she can be contacted directly and where he/she maintains patient records. (This can be the person's home address, though all Medicare rules and instructions regarding the maintenance of patient records apply.) In addition, section 4B of the CMS-855I should indicate where services are rendered (e.g., county, State, city of the patients' homes). Post office boxes are not acceptable.

If the individual answers "yes" to question 2, 3, 4, or 5, the contractor shall request a copy of the lease agreement giving him/her exclusive use of the facilities for OT services only if it has reason to question the accuracy of his/her response. If the contractor makes this request and the provider cannot furnish a copy of the lease, the contractor shall deny the application.

J. Physical Therapists in Private Practice

1. Physical Therapist in Private Practice

Section 42 CFR 410.60(c)(ii), (iii), and (iv) state that a physical therapist in private practice must:

- a. Engage in the private practice of physical therapy on a regular basis as an individual, in one of the following practice types:
 - i. An unincorporated solo practice.
 - ii. A partnership or unincorporated group practice.
 - iii. An unincorporated solo practice, partnership, or group practice, or a professional corporation or other incorporated physical therapy practice.
 - iv. An employee of a physician group.
 - v. An employee of a group that is not a professional corporation

AND

- b. Bill Medicare only for services furnished in his or her private practice office space, or in the patient's home.
 - i. A therapist's private practice office space refers to the location(s) where the practice is operated, in the state(s) where the therapist (and practice, if applicable) is legally authorized to furnish services, during the hours

that the therapist engages in practice at that location. When services are furnished in private practice office space, such space must be owned, leased, or rented by the practice and used for the exclusive purpose of operating the practice.

ii. A patient's home does not include any institution that is a hospital, a CAH, or a SNF.

AND

c. Treat individuals who are patients of the practice and for whom the practice collects fees for the services furnished.

2. Regulatory Definition

Section 42 CFR § 484.4 defines a physical therapist as a person who is licensed, if applicable, by the state in which practicing (unless licensure does not apply) and who meets one of the following requirements:

(a) Graduated after successful completion of a physical therapist education program approved by one of the following:

(i) The Commission on Accreditation in Physical Therapy Education (CAPTE).

(ii) Successor organizations of CAPTE.

(iii) An education program outside the United States determined to be substantially equivalent to physical therapist entry-level education in the United States by a credentials evaluation organization approved by the American Physical Therapy Association or an organization identified in 8 CFR § 212.15(e) as it relates to physical therapists; and

(b) Passed an examination for physical therapists approved by the state in which physical therapy services are provided.

OR

On or before December 31, 2009--

(a) Graduated after successful completion of a physical therapy curriculum approved by the Commission on Accreditation in Physical Therapy Education (CAPTE); or

(b) Meets both of the following:

(i) Graduated after successful completion of an education program determined to be substantially equivalent to physical therapist entry level education in the United States by a credentialed evaluation organization approved by the American Physical Therapy Association or identified in 8 CFR § 212.15(e) as it relates to physical therapists.

(ii) Passed an examination for physical therapists approved by the state in which physical therapy services are provided.

OR

Before January 1, 2008--

(i) Graduated from a physical therapy curriculum approved by one of the following:

(ii) The American Physical Therapy Association.

(iii) The Committee on Allied Health Education and Accreditation of the American Medical Association.

(vi) The Council on Medical Education of the American Medical Association and the American Physical Therapy Association.

OR

On or before December 31, 1977 was licensed or qualified as a physical therapist and meets both of the following:

(i) Has 2 years of appropriate experience as a physical therapist.

(ii) Has achieved a satisfactory grade on a proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service.

OR

Before January 1, 1966--

(i) Was admitted to membership by the American Physical Therapy Association; or

(ii) Was admitted to registration by the American Registry of Physical Therapists; or

Has graduated from a physical therapy curriculum in a 4-year college or university approved by a state department of education.

OR

Before January 1, 1966 was licensed or registered, and before 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.

3. Physical Therapist Trained Outside the United States

Section 42 CFR § 484.4 states that if the physical therapist was trained outside the United States before January 1, 2008, he or she must meet the following requirements:

- a. 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.
- b. Meets the requirements for membership in a member organization of the World Confederation for Physical Therapy.

4. Physical Therapists: Additional References

See Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15:

- Section 230.2(B) for more detailed information regarding the required qualifications of physical therapists.
- Section 230.4 for detailed information regarding the term “private practice.”

5. Site Visits of Physical Therapists in Private Practice

(This site visit requirement is pursuant to 42 CFR § 424.518(b).)

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

- i. Initial application – If a physical therapist (PT) or PT group submits an initial application for private practice, 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 10.6.20(A) and 10.6.20(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.
- ii. Revalidation – If a private practice 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 10.6.20(A) and 10.6.20(B) of this chapter. The NSVC will perform the site visit. The contractor shall not make a final decision regarding the revalidation application prior to the completion of the NSVC’s site visit and the contractor’s review of the results.
- iii. New/changed location – Unless CMS has directed otherwise, if a private practice 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 10.6.20(A) and 10.6.20(B) of this chapter. The NSVC will perform the site visit. The contractor shall not make a final decision regarding the application prior to the completion of the NSVC's site visit and the contractor's review of the results.

6. Physical Therapists: 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 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, this does not exempt the physical therapist from screening required at the "moderate" risk level.
- If a newly-enrolling private practice 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 private practice initial enrollment and reassignment of benefits (Form CMS-855I and Form CMS-855R). However, a site visit is not required for an enrolled private practice physical therapist who is reassigning his or her benefits only (Form CMS-855R).
- If the private practice 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.

7. Other Enrollment Information

All PTs in private practice must respond to the questions in section 2K of the CMS-855I. If the PT plans to provide his/her services as: (1) a member of an established PT group, (2) an employee of a physician-directed group, or (3) an employee of a non-professional corporation, and that person wishes to reassign his/her benefits to that group, this section does not apply. Such information will be captured on the group's CMS-855B application.

If the PT checks that he/she renders all of his/her services in patients' homes, the contractor shall verify that he/she has an established private practice where he/she can be contacted directly and where he/she maintains patient records. (This can be the person's home address, though all Medicare rules and instructions regarding the maintenance of patient records apply.) In addition, section 4E of the CMS-855I should indicate where services are rendered (e.g., county, State, city of the patients' homes). Post office boxes are not acceptable.

If the individual answers "yes" to question 2, 3, 4, or 5, the contractor shall request a copy of the lease agreement giving him/her exclusive use of the facilities for PT services only if it has reason to question the accuracy of his/her response. If the contractor makes this request and the provider cannot furnish a copy of the lease, the contractor shall deny the application.

K. Physicians

As described in § 1861(r)(1) of the Social Security Act and in 42 CFR § 410.20(b), a physician must be legally authorized to practice medicine by the state in which he/she performs such services in order to enroll in the Medicare program and to retain Medicare billing privileges. Such individuals include:

1. Doctors of:

- Medicine or osteopathy
- Dental surgery or dental medicine
- Podiatric medicine
- Optometry

2. A chiropractor who meets the qualifications specified in 42 CFR § 410.22.

Refer to Pub. 100-04, Medicare Claims Processing Manual, Chapter 19, section 40.1.2 for special licensure rules regarding practitioners who work in or reassign benefits to hospitals or freestanding ambulatory care clinics operated by the Indian Health Service or by an Indian tribe or tribal organization.

L. Physician Assistants (PAs)

Federal regulations at 42 CFR § 410.74(c), 42 CFR § 410.150(a)(15), and Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, section 190 require that a physician assistant (PA) must meet the following Medicare requirements:

- Have graduated from a physician assistant educational program that is accredited by the Accreditation Review Commission on Education for the Physician Assistant (its predecessor agencies, the Commission on Accreditation of Allied Health Education Programs (CAAHEP) and the Committee on Allied Health Education and Accreditation (CAHEA)); or

- Have passed the national certification examination that is administered by the National Commission on Certification of Physician Assistants (NCCPA); and
- Be licensed by the state to practice as a physician assistant.

As indicated in Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, section 190(D):

- Payment for the PA's services may only be made to the PA's employer, not to the PA himself/herself. In other words, the PA cannot individually enroll in Medicare and receive direct payment for his or her services. This also means that the PA does not reassign his or her benefits to the employer, since the employer must receive direct payment anyway.
- The PA's employer can be either an individual or an organization. If the employer is a professional corporation or other duly qualified legal entity (e.g., limited liability company) in a state that permits PA ownership in the entity (e.g., as a stockholder, member), the entity may bill for PA services even if a PA is a stockholder or officer of the entity – so long as the entity is eligible to enroll as a provider or supplier in the Medicare program. PAs may not otherwise organize or incorporate and bill for their services directly to the Medicare program, including as, but not limited to, sole proprietorships or general partnerships. Accordingly, a qualified employer is not a group of PAs that incorporate to bill for its services. Moreover, leasing agencies and staffing companies do not qualify under the Medicare program as providers or suppliers of services.
- PAs also have the option under their benefit to furnish services as an independent contractor (1099 employment arrangement) in which case the contractor serves as the PA's employer and Medicare payment is made directly to the contractor.

1. Other Enrollment Information

As stated in the instructions on page 3 of the CMS-855I, physician assistants (PAs) who are enrolling in Medicare need only complete sections 1, 2, 3, 13, 15, and 17 of the CMS- 855I. The physician assistant must furnish his/her NPI in section 2A of the application, and must list his/her employers in section 2I.

The contractor must verify that the employers listed are: (1) enrolled in Medicare, and (2) not excluded or debarred from the Medicare program. (An employer can only receive payment for a PA's services if both are enrolled in Medicare.) All employers must also have an established record in PECOS. If an employer is excluded or debarred, the contractor shall deny the application.

Since PAs cannot reassign their benefits – even though they are reimbursed through their employer – they should not complete a CMS-855R.

M. Psychologists Practicing Independently

Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, section 80.2 states that a psychologist practices independently when:

- He/she render services on his/her own responsibility, free of the administrative and professional control of an employer, such as a physician, institution or agency;
- The persons he/she treats are his/her own patients;
- He/she has the right to bill directly, collect and retain the fee for his/her services; and
- The psychologist is state-licensed or certified in the state where furnishing services.
- A psychologist practicing in an office located in an institution may be considered an independently practicing psychologist when both of the following conditions are met:
 - The office is confined to a separately-identified part of the facility that is used solely as the psychologist's office and cannot be construed as extending throughout the entire institution; and
 - The psychologist conducts a private practice (i.e., services are rendered to patients from outside the institution as well as to institutional patients).

Independently practicing psychologists have a more limited benefit under the Medicare program than clinical psychologists. With a degree starting at the master's level of psychology, independently practicing psychologists are authorized to bill the program directly solely for diagnostic psychological and neuropsychological tests that have been ordered by a physician, clinical psychologist or nonphysician practitioner who is authorized to order diagnostic tests. Independently practicing psychologists are not authorized to supervise diagnostic psychological and neuropsychological tests. Any tests performed by an independently practicing psychologist must fall under the psychologist's state scope of practice.

Other Enrollment Information

The contractor shall ensure that all persons who check "Psychologist Billing Independently" in section 2D2 of the CMS-855I answer all questions in section 2J. If the supplier answers "no" to question 1, 2, 3, 4a, or 4b, the contractor shall deny the application.

N. Registered Dietitians

Federal regulations at 42 CFR § 410.134 state that a registered dietitian (or nutrition professional) is an individual who, on or after December 22, 2000:

1. Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose;
2. Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional; and
3. Is licensed or certified as a dietitian or nutrition professional by the state in which the services are performed. In a state that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (1) and (2) above.

There are two exceptions to these requirements:

- A dietitian or nutritionist licensed or certified in a state as of December 21, 2000, is not required to meet the requirements of (1) and (2) above.
- A registered dietitian in good standing, as recognized by the Commission of Dietetic Registration or its successor organization, is deemed to have met the requirements of (1) and (2) above.

O. Speech Language Pathologists in Private Practice

Effective July 1, 2009, in order to qualify as an outpatient speech-language pathologist in private practice, an individual must meet the following requirements:

1. Be legally authorized (if applicable, licensed, certified, or registered) to engage in the private practice of speech-language pathology by the state in which he or she practices, and practice only within the scope of his or her license and/or certification.
2. Engage in the private practice of speech-language pathology as an individual, in one of the following practice types:
 - a. An unincorporated solo practice
 - b. An unincorporated partnership or unincorporated group practice
 - c. An unincorporated solo practice, partnership, or group practice, or a professional corporation or other incorporated speech-language pathology practice
 - d. An employee of a physician group
 - e. An employee of a group that is not a professional corporation

For more information on speech language pathologists in private practice, refer to Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, section 230.

P. Manufacturers of Replacement Parts/Supplies for Prosthetic Implants or Implantable Durable Medical Equipment (DME) Surgically Inserted at an ASC

Since Part A/B MACs make payments for implantable prosthetics and DME to hospitals, physicians or ASCs, A/B MACs shall not enroll manufacturers of implantable or non-implantable and prosthetics DME into the Medicare program. A manufacturer of non-implantable prosthetics and DME and replacement parts and supplies for prosthetic implants and surgically implantable DME may enroll in the Medicare program as a supplier with the National Supplier Clearinghouse if it meets the definition of a supplier as well as the requirements in 42 CFR § 424.57.

10.2.4 - Other Medicare Part B Services

(Rev. 10611; Issued: 03-19-21; Effective: 11-19-20; Implementation: 11-19-20)

A. Residents and Interns

1. General Background Information

If the applicant is a "resident" in an "approved medical residency program" (as these two terms are defined at 42 CFR §413.75(b)), the contractor shall refer to Pub. 100-02, chapter 15, section 30.3 for further instructions. (The contractor may also want to refer to 42 CFR §415.200, which states that services furnished by residents in approved programs are not "physician services.")

The physician should indicate the exact date that its residency program, internship, or fellowship was completed, so that the appropriate effective date can be issued.

2. Interns are Ineligible to Enroll in the Medicare Program

An intern cannot enroll in the Medicare program. (For purposes of this requirement, the term "intern" means an individual who is not licensed by the State because he/she is still in post-graduate year (PGY) 1.)

B. Diabetes Self-Management Training (DSMT)

DSMT Background

Diabetes self-management training (DSMT) is not a separately recognized provider type, such as a physician or nurse practitioner. A person or entity cannot enroll in Medicare for the sole purpose of performing DSMT. Rather, DSMT is an extra service that an enrolled provider or supplier can bill for, assuming it meets all of the necessary DSMT requirements. If the person or entity enrolls as a provider type (i.e., pharmacy, mass immunizer) that requires the submission of an application fee, the fee shall be submitted with the application.

All DSMT programs must be accredited as meeting quality standards by a CMS-approved national accreditation organization. Currently, CMS recognizes the American Diabetes Association (ADA) and the Association of Diabetes Care & Education Specialists (ADCES) (formerly known as the American Association of Diabetes Educators or AADE) as approved national accreditation organizations. A Medicare-enrolled provider or non-DMEPOS supplier that wishes to bill for DSMT may simply submit the appropriate accreditation certificate to its contractor. No Form CMS-855 is required, unless the provider or supplier is not in the Provider Enrollment, Chain and Ownership System (PECOS), in which case a complete Form CMS-855 application must be submitted.

If the supplier is exclusively a DMEPOS supplier, it must complete and submit a Form CMS-855B application to its local Part A/B MAC. This is because A/B MACs, rather than Durable Medical Equipment Medicare Administrative Contractors, pay DSMT claims. Thus, the DMEPOS supplier must separately enroll with its A/B MAC, even if it has already completed a Form CMS-855S. If an A/B MAC receives an application from a DMEPOS supplier that would like to bill for DSMT, it shall verify with the National Supplier Clearinghouse that the applicant is currently enrolled and eligible to bill the Medicare program.

For more information on DSMT, refer to:

- 42 CFR Part 410 (subpart H)
- Publication 100-02, Medicare Benefit Policy Manual, chapter 15, sections 300 – 300.5.1

C. Mass Immunizers Who Roster Bill

An entity or individual who wishes to furnish mass immunization services - but may not otherwise qualify as a Medicare provider - may be eligible to enroll as a “Mass Immunizer” via the Form CMS-855I (individuals) or the Form CMS-855B (entities). Such suppliers must meet the following requirements:

1. They may not bill Medicare for any services other than pneumococcal pneumonia vaccines (PPVs), influenza virus vaccines, and their administration.
2. They must submit claims through the roster billing process.
3. The supplier, as well as all personnel who administer the shots, must meet all applicable state and local licensure or certification requirements.

The roster billing process was developed to enable Medicare beneficiaries to participate in mass PPV and influenza virus vaccination programs offered by public health clinics and other organizations.

In addition:

- The effective date provision in 42 CFR § 424.520(d) does not apply to the enrollment of mass immunizers. This is because the individual/entity

is not enrolling as a physician, non-physician practitioner, physician group or non-physician practitioner group.

- In section 4 of the Form CMS-855, the supplier need not list each off-site location (e.g., county fair, shopping mall) at which it furnishes services. It need only list its base of operations (e.g., county health department headquarters, drug store location).

For more information on mass immunization roster billing, refer to:

- Publication 100-02, Benefit Policy Manual, chapter 15, section 50.4.4.2
- Publication 100-04, Claims Processing Manual, chapter 18, sections 10 through 10.3.2.3

D. Advanced Diagnostic Imaging

Section 135(a) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) amended section 1834(e) of the Social Security Act. It required the Secretary to designate organizations to accredit suppliers – including, but not limited to, physicians, non-physician practitioners and independent diagnostic testing facilities - that furnish the technical component (TC) of advanced diagnostic imaging services. MIPPA specifically defines advanced diagnostic imaging procedures as including diagnostic magnetic resonance imaging (MRI), computed tomography (CT), and nuclear medicine imaging such as positron emission tomography (PET). The law also authorizes the Secretary to specify other diagnostic imaging services in consultation with physician specialty organizations and other stakeholders. In order to furnish the TC of advanced diagnostic imaging services for Medicare beneficiaries, suppliers must be accredited by January 1, 2012. The effective date of the previously named regulation is January 1, 2012.

CMS approved four national accreditation organizations (AOs) – the American College of Radiology, the Intersocietal Accreditation Commission, the Joint Commission and Rad Site - to provide accreditation services for suppliers of the TC of advanced diagnostic imaging procedures. The accreditation will apply only to the suppliers of the images, not to the physician's interpretation of the image. Also, this accreditation only applies to those who are paid under the Physician Fee Schedule. All accreditation organizations have quality standards that address the safety of the equipment as well as the safety of the patients and staff. A provider submitting claims for the TC must be accredited by January 1, 2012 to be reimbursed for the claim if the service is performed on or after that date. Each of these designated AOs submits monthly reports to CMS that list the suppliers who have been or are accredited, as well as the beginning and end date of the accreditation and the respective modalities for which they receive accreditation.

Newly enrolling physicians and non-physician practitioners described above do not need to complete the appropriate boxes for Advanced Diagnostic Imaging (ADI) on Internet-based PECOS or the appropriate CMS-855. Information for all ADI accredited suppliers is provided to CMS from the approved ADI

Accreditation Organizations. The Medicare enrollment contractors do not need to verify ADI information sent on the application.

10.2.5 – Suppliers That Enroll Via the Form CMS-855S **(Rev. 10611; Issued: 03-19-21; Effective:11-19-20; Implementation: 11-19-20)**

A. Suppliers of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)

1. Special Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Instructions

Sections 10.2.5(A)(1) through 10.2.5(A)(2) instruct the National Supplier Clearinghouse on the appropriate handling of certain situations involving DMEPOS suppliers.

2. DMEPOS Supplier Accreditation

a. General Requirement

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

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

In the future, Medicare will deny claims for those DMEPOS suppliers who fail to maintain accreditation information on file with the NSC.

b. Exemptions

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

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

c. Special Situations

Changes of Ownership

i. Change of Ownership and Accreditation

A change of ownership application for an existing supplier location submitted by a new owner company with a new tax identification number (TIN) shall be denied (consistent with 42 CFR § 424.57) if the new owner does not have an accreditation that covers all of its locations. If the old owner has such an accreditation, the new owner can be enrolled as of the date of sale if the accreditor determines that the accreditation should remain in effect as of the date of sale. (This, however, is only applicable when the new owner also meets all other enrollment criteria found at 42 CFR §424.57).

ii. Change of Ownership Involving More than 5 Percent of the Ownership Interest

Some ownership changes do not result in a complete change of ownership, since the business entity remains the same with no change in TIN. However, in cases where more than 5 percent of the ownership has changed, the following principles apply:

- If the change in ownership has not been reported to the NSC within the required 30-day period, the NSC shall proceed with revocation action.
- If the change has been received within the required 30-day period and the supplier has been accredited, the NSC shall immediately notify the accreditor of the ownership change and request that the latter advise the NSC if the accreditation should still remain in effect.

iii. Accreditation and Deactivation/Revocation

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

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

d. Fraud Level Indicators for DMEPOS Suppliers - Development and Use

The National Supplier Clearinghouse (NSC) shall perform a fraud potential analysis of all DMEPOS applicants and current DMEPOS suppliers. The fraud level indicator shall represent the potential for fraud and/or abuse. The NSC shall use four fraud level indicator codes as follows:

- Low Risk (e.g., national drug store chains)
- Limited Risk (e.g., prosthetist in a low fraud area)

- Medium Risk (e.g., midsize general medical supplier in a high fraud area)
- High Risk (e.g., very small space diabetic supplier with low inventory in a high fraud area whose owner has previously had a chapter 7 bankruptcy). High fraud areas shall be determined by contractor analysis with concurrence of the NSC project officer.

(**NOTE:** These risk categories are in addition to, and not in lieu of, those specified in Section 10.4(G)(2) of this chapter.)

In assessing a fraud level indicator, the NSC shall consider such factors as:

- Experience as a DMEPOS supplier with other payers
- Prior Medicare experience
- The geographic area
- Fraud potential of products and services listed
- Site visit results
- Inventory observed and contracted
- Accreditation of the supplier

After a fraud level indicator is assigned and the DMEPOS supplier is enrolled, the NSC shall establish a DMEPOS Review Plan based on the fraud level assessment. The DMEPOS Review Plan shall contain information regarding:

- Frequency of unscheduled site visits
- Maximum billing amounts before recommendation for prepay medical review
- Maximum billing spike amounts before recommendation for payment suspensions/prepay medical review, etc.

The fraud level indicator shall be updated based upon information obtained through the Medicare enrollment process, such as reported changes of information.

Information obtained by the Office of Inspector General (OIG), CMS (including CMS satellite office), and/or a Unified Program Integrity Contractor (UPIC) shall be reported to the NSC project officer. The NSC shall update the fraud level indicator based on information obtained by the OIG, CMS (including CMS satellite office), and/or a UPIC only after the review and concurrence of the NSC project officer.

In addition, the NSC shall monitor and assess geographic trends which indicate or demonstrate that one geographic area has a higher potential for having fraudulent suppliers.

e. A DMEPOS Fraud Level Indicator Differs From Risk Screening Category under 42 CFR §424.518

The fraud level indicator described in this subsection is unrelated to the risk screening categories required under 42 CFR §424.518. Under §424.518(c)(1)(ii), for example, newly enrolling DMEPOS suppliers are assigned to the “high” risk screening category. Such DMEPOS suppliers are therefore subject to screening activities that correspond to the “high” risk screening category, including, and not limited to an on-site visit and a fingerprint-based criminal background check for all individuals who maintain a 5 percent or greater direct or indirect ownership interest in the supplier §424.518(c)(2). The on-site visits that the NSC conducts are responsive to the requirement at §424.518(c)(2)(i) for a site visit and include gathering information concerning fraud level indicator assignment as required in this subsection. A DMEPOS supplier therefore has both a risk based screening category assignment pursuant to requirements under §424.518, and a separate fraud level indicator based upon the guidance in this subsection.

f. Fraud Level Indicator Standards

The NSC shall have documented evidence that it has, at a minimum, met the following requirements:

- Assign an appropriate fraud level indicator for at least 95 percent of all DMEPOS suppliers, upon initial enrollment or revalidation. The fraud level indicator shall accurately reflect the risk the supplier poses to the Medicare program based on pre-defined criteria above.
- Update the DMEPOS fraud level indicator for each enrolled DMEPOS supplier on an annual basis.

g. Alert Codes for DME Suppliers

The NSC shall receive and maintain the following “alert indicators” from the DME MACs, and Unified Program Integrity Contractors (UPICs):

| Alert Code | Definition |
|------------|--|
| A | Possible fraudulent or abusive claims identified |
| B | Overpayments |
| D | Violations of disclosure of ownership requirements |
| E | Violations of participation agreements |

| | |
|---|--|
| L | Suspended by contractor outside alert code process |
|---|--|

| | |
|---|---|
| M | Supplier is going through claims appeal process |
|---|---|

The NSC shall append the supplier file and transfer to the DME-MACs, UPICs and/or UPICs the following alert codes in the following circumstances:

| Alert Code | Definition |
|------------|------------|
|------------|------------|

C Violations of supplier standards

F Excluded by the Office of Inspector General or debarred per
the GSA debarment list

H Meets supplier standards; however, the NSC recommends increased scrutiny by the contractor (initiated by NSC-MAC only)

N Supplier being investigated under the "Do Not Forward" initiative (initiated by NSC only)

| Q | Low Risk Fraud Level Indicator |
|---|--------------------------------|
|---|--------------------------------|

| | |
|---|------------------------------------|
| R | Limited Risk Fraud Level Indicator |
|---|------------------------------------|

Medium Risk Fraud Level Indicator

| T | High Risk Fraud Level Indicator |
|---|---------------------------------|
|---|---------------------------------|

The NSC shall append an Alert Code "H" for any supplier that meets present supplier standards but appears suspect in one of the areas that are verified by the NSC. This alert code notifies the contractors that a supplier may be inclined to submit a high percentage of questionable claims.

The NSC shall share the above information with the DME MACs, and/or UPICs by sending alerts within 7 calendar days after identification of a supplier having common ownership or business ties with a sanctioned or suspect supplier for their research and/or action. The NSC also shall forward alert codes submitted by the contractors with the other contractors within 7 calendar days after receipt.

3. Surety Bonds

a. Background

i. Surety Bond Exemptions

All DMEPOS suppliers are subject to the surety bond requirement, except:

- (1) Government-operated DMEPOS suppliers are exempted if the supplier has provided CMS with a comparable surety bond under State law.

- (2) State-licensed orthotic and prosthetic personnel (which, for purposes of the surety bond requirement, does not include pedorthists) in private practice making custom-made orthotics and prosthetics are exempted if—
- The business is solely-owned and operated by the orthotic and prosthetic personnel, and
 - The business is only billing for orthotic, prosthetics, and supplies.
- (3) Physicians and non-physician practitioners, as defined in section 1842(b)(18) of the Social Security Act, are exempted if the items are furnished only to the physician or non-physician practitioner's own patients as part of his or her physician service. The non-physicians covered under this exception are: physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse-midwives, clinical social workers, clinical psychologists, and registered dietitians or nutrition professionals.
- (4) Physical and occupational therapists in private practice are exempted if—
- The business is solely-owned and operated by the physical or occupational therapist;
 - The items are furnished only to the physical or occupational therapist's own patients as part of his or her professional service; and
 - The business is only billing for orthotics, prosthetics, and supplies.

If a previously-exempted DMEPOS supplier no longer qualifies for an exception, it must submit a surety bond to the NSC - in accordance with the requirements in 42 CFR §424.57 - within 60 days after it knows or has reason to know that it no longer meets the criteria for an exception.

b. Bond Submission

Effective May 4, 2009, DMEPOS suppliers submitting: (1) an initial enrollment application to enroll in the Medicare program for the first time, (2) an initial application to establish a new practice location, or (3) an enrollment application to change the ownership of an existing supplier, are required to obtain and submit a copy of its required surety bond to the NSC with their CMS-855S enrollment application. (**NOTE:** Ownership changes that do not involve a change in the status of the legal entity as evidenced by no change in the tax identification number, or changes that result in the same ownership at the level of individuals (corporate reorganizations and individuals incorporating) are not considered to be "changes of ownership" for purposes of the May 4, 2009, effective date – meaning that such suppliers are considered "existing" suppliers).

For any CMS-855S application submitted on or after May 4, 2009, by a supplier described in this section (2), the NSC shall reject the application if the supplier does not furnish a valid surety bond at the time it submits its application. The rejection shall be done in accordance with existing procedures (e.g., reject application after 30 days).

c. Amount and Basis

The surety bond must be in an amount of not less than \$50,000 and is predicated on the NPI, not the tax identification number. Thus, if a supplier has two separately-enrolled DMEPOS locations, each with its own NPI, a \$50,000 bond must be obtained for each site.

A supplier may obtain a single bond that encompasses multiple NPIs/locations. For instance, if a supplier has 10 separately-enrolled DMEPOS locations, it may obtain a \$500,000 bond that covers all 10 locations.

As stated in 42 CFR §424.57(d)(3), a supplier will be required to maintain an elevated surety bond amount of \$50,000 for each final adverse action imposed against it within the 10 years preceding enrollment or reenrollment. This amount is in addition to, and not in lieu of, the base \$50,000 amount that must be maintained. Thus, if a supplier has had two adverse actions imposed against it, the bond amount will be \$150,000.

- A final adverse action is one of the following:
- A Medicare-imposed revocation of Medicare billing privileges;
- Suspension or revocation of a license to provide health care by any State licensing authority;
- Revocation or suspension by an accreditation organization;
- A conviction of a Federal or State felony offense (as defined in §424.535(a)(3)(i)) within the last 10 years preceding enrollment or re-enrollment; or
- An exclusion or debarment from participation in a Federal or State health care program.

d. Bond Terms

The supplier is required to submit a copy of the bond that - on its face - reflects the requirements of 42 CFR §424.57(d). Specific terms that the bond must contain include:

- A guarantee that the surety will - within 30 days of receiving written notice from CMS containing sufficient evidence to establish the surety's liability under the bond of unpaid claims, civil monetary

penalties (CMPs), or assessments - pay CMS a total of up to the full penal amount of the bond in the following amounts:

- The amount of any unpaid claim, plus accrued interest, for which the DMEPOS supplier is responsible, and
- The amount of any unpaid claims, CMPs, or assessments imposed by CMS or the OIG on the DMEPOS supplier, plus accrued interest.
- A statement that the surety is liable for unpaid claims, CMPs, or assessments that occur during the term of the bond.
- A statement that actions under the bond may be brought by CMS or by CMS contractors.
- The surety's name, street address or post office box number, city, State, and zip code.
- Identification of the DMEPOS supplier as the Principal, CMS as the Obligee, and the surety (and its heirs, executors, administrators, successors and assignees, jointly and severally) as the surety.

The term of the initial surety bond must be effective on the date that the application is submitted to the NSC. Moreover, the bond must be continuous.

e. Sureties

The list of sureties from which a bond can be secured is found at Department of the Treasury's "Listing of Certified (Surety Bond) Companies;" the Web site is https://www.fiscal.treasury.gov/fsreports/ref/suretyBnd/c570_a-z.htm. For purposes of the surety bond requirement, these sureties are considered "authorized" sureties, and are therefore the only sureties from which the supplier may obtain a bond.

f. Bond Cancellations and Gaps in Coverage

A DMEPOS supplier may cancel its surety bond, but must provide written notice of such to the NSC and the surety at least 30 days before the effective date of the cancellation. Cancellation of a surety bond is grounds for revocation of the supplier's Medicare billing privileges unless the supplier provides a new bond before the effective date of the cancellation. The liability of the surety continues through the termination effective date.

If a gap in coverage exists, the NSC shall revoke the supplier's billing privileges. If a supplier changes its surety during the term of the bond, the new surety is responsible for any overpayments, CMPs, or assessments incurred by the DMEPOS supplier beginning with the effective date of the new surety bond; the previous surety is responsible for any overpayments, CMPs, or assessments that occurred up to the date of the change of surety.

Pursuant to 42 CFR 424.57(d)(6)(iv), the surety must notify the NSC if there is a lapse in the surety's coverage of the DMEPOS supplier. This can be done via letter, fax, or e-mail to the NSC; the appropriate addresses can be found on the NSC's Web site at www.palmettogba.com/nsc.

g. Reenrollment and Reactivation

The supplier must furnish the paperwork described in subsection (A)(4) above with any CMS-855S reenrollment or reactivation application it submits to the NSC unless it already has the information on file with the NSC. For example, if a supplier has submitted a continuous surety bond to the NSC prior to submission of its reenrollment application, a new copy of surety bond is not be required unless the NSC specifically requests it.

h. Surety Bond Changes

A DMEPOS supplier must submit an addendum to the existing bond (or, if the supplier prefers, a new bond) to the NSC in the following instances: (1) change in bond terms, (2) change in bond amount, or (3) a location on a bond covering multiple non-chain locations is being added or deleted.

i. Claims against Surety Bonds

Pursuant to 42 CFR §424.57(d)(5)(i), the surety must pay CMS - within 30 days of receiving written notice to do so - the following amounts up to the full penal sum of the bond:

- i. The amount of any unpaid claim, plus accrued interest, for which the supplier of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) is responsible.
- ii. The amount of any unpaid claim, civil monetary penalty (CMP) or assessment imposed by CMS or the Office of Inspector General (OIG) on the DMEPOS supplier, plus accrued interest.

This section 10.2.5(A)(3)(i) describes the procedures involved in making a claim against a surety bond.

j. Unpaid Claims

i. Background

For purposes of the surety bond requirement, 42 CFR §424.57(a) defines an "unpaid claim" as an overpayment (including accrued interest, as applicable) made by the Medicare program to the DMEPOS supplier for which the supplier is responsible.

The policies in this section 10.2.5(A) only apply to overpayment determinations relating to demands first made on or after March 3, 2009. A surety is liable for any overpayments based on dates of service occurring during the term of the surety bond. (For purposes of determining surety liability, the date of the initial demand letter was sent to the provider is the date on which the service was

performed/furnished.) Even if the overpayment determination is made after the expiration of the surety bond, the surety remains liable if the date of service was within the surety bond coverage period. In short, the date of service – rather than the date of the overpayment determination, the date the overpayment or demand letter was sent to the supplier---is the principal factor in ascertaining surety liability.

As an illustration, assume that a supplier has a surety bond with Company X on August 1, 2015. It performs a service on October 1, 2015. The supplier ends its coverage with Company X effective January 1, 2016 and obtains a new surety bond with Company Y effective that same date. On February 1, 2016, CMS determines that the October 1, 2015 service resulted in an overpayment; on March 2, 2016, CMS sends an overpayment demand letter to the supplier. While the overpayment determination and the sending of the demand letter occurred during Company Y's coverage period, the date of service was within the Company X coverage period. Thus, liability (and responsibility for payment) rests with Company X, even though the supplier no longer has a surety bond with X.

k. Collection

i. Delinquency Period

If the Durable Medical Equipment Medicare Administrative Contractor (DME MAC) determines – in accordance with CMS's existing procedures for making overpayment determinations - that (1) the DMEPOS supplier has an unpaid claim for which it is liable, and (2) no waiver of recovery under the provisions of Section 1870 of the Social Security Act is warranted, the DME MAC shall attempt to recover the overpayment in accordance with the instructions in CMS Pub. 100-06, chapter 4.

If 80 days have passed since the initial demand letter was sent to the DMEPOS supplier and full payment has not been received, the DME MAC shall attempt to recover the overpayment. The DME MAC shall review the "List of Bonded Suppliers" the last week of each month to determine which suppliers that have exceeded this 80-day period have a surety bond. Said list:

- Will be electronically sent to the DME MACs by the Provider Enrollment & Oversight Group on a monthly basis.
- Will be in the form of an Excel spreadsheet.
- Will contain the supplier's legal business name, tax identification number, NPI, surety bond amount and other pertinent information.

If the supplier does not have a surety bond (i.e., is exempt from the surety bond requirement), the DME MAC shall continue to follow the instructions in Pub. 100-06, chapter 4 regarding collection of the overpayment.

ii. Request for Payment from Surety

If, however, the supplier has a surety bond (and subject to situations (1) through (6) below), the DME MAC shall send an “Intent to Refer” (ITR) letter to the supplier and a copy thereof to the supplier’s surety. The letter ITR and copy shall be sent to the supplier on day 66 after the initial demand letter was sent, and the surety notification shall be sent within 5 days. (The copy to the surety can be sent via mail, e-mail, or fax.)

(NOTE: Under federal law, a delinquent debt must be referred to the Department of Treasury within 120 days. (Per the chart below, this represents Day 150 of the entire collection cycle.) To ensure that the DME MAC meets this 120-day limit yet has sufficient time to prepare the surety letter as described in the following paragraph, it is recommended that the DME MAC send the ITR letter several days prior to the 90-day limit referenced in the previous paragraph. This will give the DME MAC a few additional days beyond the 30-day deadline referenced in the next paragraph to send the surety letter.)

If the DME MAC does not receive full payment from the supplier within 30 days of sending the ITR letter (and subject to situations (1) through (6) below), the contractor shall notify the surety via letter that in accordance with 42 CFR §424.57(d)(5)(i)(A), the surety must make payment of the claim to CMS within 30 days from the date of the surety letter. (The DME MAC shall send a copy of the surety letter to the supplier on the same date.) The DME MAC shall send the surety letter no later than 30 days after sending the ITR letter (subject to the previous paragraph), depending on the facts of the case. Consider the following situations:

1. If a DMEPOS supplier has withdrawn from Medicare or has had its enrollment deactivated or revoked, the contractor shall send the ITR and the surety letter on the earliest possible day.
2. If the supplier has an extended repayment schedule (ERS) and is currently making payments, the DME MAC shall not send an ITR letter or a surety letter. If the DME MAC is currently reviewing an ERS application from the supplier, the contractor shall delay sending the ITR letter and the surety letter until after the ERS review is complete.
3. If the aggregated principal balance of the debt is less than \$25, the DME MAC shall not send an ITR letter or a surety letter. It shall instead follow the instructions in CMS Pub. 100-06, chapter 4 regarding collection of the overpayment.
4. If the DME MAC believes the debt will be collected through recoupment, it shall not send an ITR letter or a surety letter. It shall instead follow the instructions in Pub. 100-06, chapter 4 regarding collection of the overpayment.
5. If the supplier has had a recent offset, the DME MAC may wait to see if future offsets will close the debt, without sending the surety a letter. If the debt is still not paid in full or an ERS has not been

established, the DME MAC shall send the surety letter no later than the 115th day after the initial demand letter was sent.

l. A payment demand letter shall not be sent to the surety if the DME MAC is certain that the \$50,000 surety bond amount in question has been completely exhausted.

The DME MAC may choose to aggregate debts from the same supplier into one surety letter, provided they are at least 30 days delinquent.

The surety letter shall:

- Follow the format of the applicable model letter found in Section 10.7.16 of this chapter.
- Identify the specific amount to be paid and be accompanied by “sufficient evidence” of the unpaid claim. “Sufficient evidence” is defined in 42 CFR §424.57(a) as documents that CMS may supply to the DMEPOS supplier’s surety to establish that the supplier had received Medicare funds in excess of the amount due and payable under the statute and regulations.
- Be accompanied by the following documents, which constitute “sufficient evidence” for purposes of §424.57(a):

m. Overpayment Services Report

A computer-generated “Overpayment Services Report” containing the following information:

- i. Date of service (i.e., the date the service was furnished/performed, not the date of the overpayment determination or the date of the overpayment or demand letter)
- ii. Date on which supplier was paid
- iii. Paid Amount
- vi. Overpayment Amount

(NOTE: The report shall not include HICN, or any information otherwise protected under the Privacy Act.)

n. A copy of the overpayment determination letter that was sent to the supplier.

- State that payment shall be made via check or money order and that the Payee shall be the DME MAC.
- Identify the address to which payment shall be sent.

The DME MAC shall only seek repayment up to the full penal sum amount of the surety bond. Thus, if the supplier has a \$60,000 unpaid claim and the amount of the supplier’s bond coverage is \$50,000, the DME MAC shall

only seek the \$50,000 amount. The remaining \$10,000 will have to be obtained from the supplier via the existing overpayment collection process.

i. Follow-Up Contact

Between 8 and 12 calendar days after sending the surety letter, the DME MAC shall contact the surety by telephone or e-mail to determine whether the surety received the letter and, if it did, whether and when payment will be forthcoming.

If the surety indicates that it did not receive the letter, the DME MAC shall immediately fax or e-mail a copy of the letter to the surety. The surety will have 30 days from the original date of the letter – not 30 days from the date the letter was resent to the surety – to submit payment. To illustrate, suppose the DME MAC on April 1 sends the surety letter, which is also dated April 1. It places the follow-up call to the surety on April 11. The surety states that it never received the letter, so the contractor e-mails a copy of it to the surety that same day. Payment must be received by May 1, or 30 days from the original date of the letter.

If the surety cannot be reached (including situations where a voicemail message must be left) or if the surety indicates that it did receive the letter and that payment is forthcoming, no further action by the contractor is required. If the surety indicates that payment is not forthcoming, the contractor shall (1) attempt to ascertain the reason, and (2) follow the steps outlined in section (A)(3)(b) below after the 30-day period expires.

The contractor shall document any attempts to contact the surety by telephone and the content of any resultant conversations with the surety.

o. Verification of Payment

i. Full Payment of the Claim is Made

If full payment (including interest, as applicable) is made within the aforementioned 30-day period, the DME MAC shall, no later than 10 calendar days after payment was made:

- A. Update all applicable records to reflect that payment was made. (Payment from the surety shall be treated as payment from the supplier for purposes of said record updates.)
- B. Send a mailed, faxed, or (preferably) e-mailed letter to the supplier (on which the NSC shall be copied):
 - Stating that payment has been made, the date the payment was received, and the amount of the payment
 - Containing the following quoted verbiage:

“You must, within 30 calendar days of the date of this letter, obtain and submit to the NSC additional surety bond coverage in the

amount of (insert the amount that the surety paid) so as to ensure that your total coverage equals or exceeds the required \$50,000 amount” (or higher if an elevated bond amount is involved due to a final adverse action). **“Failure to timely do so will result in the revocation of your Medicare enrollment.”**

“Additional surety bond coverage may be obtained by (1) adding to the amount of your existing surety bond so as to equal or exceed \$50,000, or (2) cancelling your current surety bond and securing a new \$50,000 surety bond. (Obtaining a separate (insert the amount the surety paid) surety bond is impermissible.) In either case, the effective date of the additional coverage must be on or before the date that you submit the additional coverage to the NSC.

If the NSC does not receive the additional bond coverage within this 30-day period, it shall revoke the DMEPOS supplier’s Medicare enrollment under § 424.535(a)(1) in accordance with existing procedures. (The effective date of revocation shall be the date on which the DME MAC received payment from the surety.) It is important that the NSC (1) monitor the supplier’s surety bond status upon receiving a copy of the DME MAC’s letter to the supplier and (2) take prompt action against the supplier (consistent with existing procedures) if the supplier does not secure and timely submit the required additional coverage.

ii. No Payment of the Claim Made

If the surety fails to make any payment within 30 calendar days of the date of the letter to the surety, the DME MAC shall:

A. Refer the debt to the Department of Treasury (by HIGLAS on the 120-day deadline) immediately upon the expiration of said 30-day timeframe (i.e., preferably on the same day or the day after, but in all cases no later than the 120-day deadline for sending delinquent debts to the Department of Treasury) and as outlined in Pub. 100-06, chapter 4;

B. No later than 14 days after the 30-day period expires, contact the surety via e-mail or telephone to ascertain the reason for non-payment. Only one contact is necessary. A voice mail message may be left. The contractor shall document any attempts to contact the surety by telephone and the content of any resultant conversations with the surety.

C. No later than 14 days after Step 2 has been completed – and if full payment still has not been received -- send the letter found in Section 10.7.16 of this chapter.

D. Include information relating to the surety’s non-payment in the report identified in section 10.2.5(A)(3)(o)(ii).

iii. Partial Payment of the Claim is Made

If the surety pays part of the claim within the 30-day period and a balance is still due and owing, the DME MAC shall do the following:

- A. Refer the unpaid debt to the Department of Treasury (by HIGLAS on the 12-day deadline) immediately upon the expiration of said 30-day timeframe (i.e., preferably on the same day or the day after, but in all cases no later than the 120-day deadline for sending delinquent debts to the Department of Treasury) and as outlined in Pub. 100-06, chapter 4;
- B. No later than 14 days after the 30-day period expires, contact the surety via e-mail or telephone to ascertain the reason for the partial non-payment. Only one contact is necessary. A voice mail message may be left. The contractor shall document any attempts to contact the surety by telephone and the content of any resultant conversations with the surety.
- C. No later than 14 days after Step (ii) has been completed – and if full payment still has not been received -- send the letter found in Section 10.7.16 of this chapter.
- D. Include information relating to the surety's partial non-payment in the report identified in section 10.2.5(A)(3)(o)(iii).
- E. No later than 10 calendar days after the partial payment was made:
 - Update all applicable records to reflect that partial payment was made. (Payment from the surety shall be treated as payment from the supplier for purposes of said record updates.)
 - Send a mailed, faxed, or (preferably) e-mailed letter to the supplier (on which the NSC shall be copied):
 - Stating that partial payment was made, the date the payment was received, and the amount of said payment
 - Containing the following quoted verbiage:

“You must, within 30 calendar days of the date of this letter, obtain and submit to the NSC additional surety bond coverage in the amount of (insert the amount that the surety paid) so as to ensure that your total coverage equals or exceeds the required \$50,000 amount” (or higher if an elevated bond amount is involved due to a final adverse action). **“Failure to timely do so will result in the revocation of your Medicare enrollment.”**

“Additional surety bond coverage may be obtained by (1) adding to the amount of your existing surety bond so as to equal or exceed \$50,000, or (2) cancelling your current surety bond and securing a new \$50,000 surety bond. (Obtaining a separate (insert the amount the surety paid) surety bond is impermissible.) In either case, the

effective date of the additional coverage must be on or before the date that you submit the additional coverage to the NSC.”

If the NSC does not receive the additional bond coverage within this 30-day period, it shall revoke the DMEPOS supplier’s Medicare enrollment under § 424.535(a)(1) in accordance with existing procedures. (The effective date of revocation shall be the date on which the DME MAC received payment from the surety.) It is important that the NSC (1) monitor the supplier’s surety bond status upon receiving a copy of the DME MAC’s letter to the supplier and (2) take prompt action against the supplier (consistent with existing procedures) if the supplier does not secure and timely submit the required additional coverage.

iv. Successful Appeal

If the supplier successfully appeals the overpayment and the surety has already made payment to the DME MAC on the overpayment, the DME MAC shall – within 30 calendar days of receiving notice of the successful appeal - notify the surety via letter of the successful appeal and repay the surety via check or money order.

v. Summary

The following chart outlines the timeframes involved in the surety bond collection process for overpayments:

| | |
|---------|------------------------------------|
| Day 1 | Initial Demand Letter Sent |
| Day 31 | Debt is Delinquent/Interest Starts |
| Day 41 | Recoupment Starts |
| Day 66 | Intent to Refer Letter Sent |
| Day 115 | Surety Bond Letter Sent |
| Day 150 | Referral to Treasury |

4. Surety Bonds: Claims Pertaining to Assessments and Civil Monetary Penalties (CMPs)

a. Request for Payment from Surety

Per 42 CFR §424.57(a), an assessment is defined as a “sum certain that CMS or the OIG may assess against a DMEPOS supplier under Titles XI, XVIII, or XXI of the Social Security Act.” Under 42 CFR §424.57(a), a CMP is defined as a sum that CMS has the authority, as implemented by 42 CFR §402.1(c) (or the OIG has the authority, under section 1128A of the Act or 42 CFR Part 1003) to impose on a supplier as a penalty.

CMS will notify the DME MAC of the need for the latter to collect payment from the surety on an assessment or CMP imposed against a particular bonded DMEPOS supplier. Upon receipt of this notification, the DME MAC shall – regardless of the amount of the assessment or CMP - notify the surety

via letter that, in accordance with 42 CFR § 424.57(d)(5)(i)(B), payment of the assessment or CMP must be made within 30 calendar days from the date of the letter. The letter (on which the NSC and the supplier/debtor shall be copied) shall:

- Follow the format of the applicable model letter found in Section 10.7.16 of this chapter.
- Identify the specific amount to be paid and be accompanied by “sufficient evidence.” This includes all documentation that CMS (in its notification to the DME MAC as described above) requests the DME MAC to include with the letter (e.g., OIG letter).
- State that payment shall be made via check or money order and that the Payee shall be CMS.
- Identify the address to which payment shall be sent.

i. Follow-Up Contact

Between 8 and 12 calendar days after sending the surety letter, the DME MAC shall contact the surety by telephone or e-mail to determine whether the surety received the letter and, if it did, whether and when payment is forthcoming;

If the surety indicates that it did not receive the letter, the DME MAC shall immediately fax or e-mail a copy of the letter to the surety. The surety will have 30 days from the original date of the letter – not 30 days from the date the letter was resent to the surety – to submit payment. To illustrate, suppose the DME MAC on April 1 sends the surety letter, which is also dated April 1. It places the follow-up call to the surety on April 11. The surety states that it never received the letter, so the contractor e-mails a copy of it to the surety that same day. Payment must be received by May 1, or 30 days from the original date of the letter.

If the surety cannot be reached (including situations where a voicemail message must be left) or if the surety indicates that it received the letter and that payment is forthcoming, no further action by the contractor is required. If the surety indicates that payment is not forthcoming, the contractor shall (1) attempt to ascertain the reason, and (2) follow the steps outlined in section (A)(3)(b) below after the 30-day period expires.

The contractor shall document any attempts to contact the surety by telephone and the content of any resultant conversations with the surety.

ii. Verification of Payment

A. Full Payment of the Claim is Made

If full payment (including interest, as applicable) is made within 30 calendar days of the date of the letter to the surety, the DME MAC shall, no later than 10 calendar days after payment was made:

1. Update all applicable records to reflect that payment was made. (Payment from the surety shall be treated as payment from the supplier for purposes of said record updates.)
 2. Notify the applicable CMS Regional Office (RO) via letter or e-mail that payment was made.
 3. If the OIG imposed the CMP or assessment, notify the OIG via letter that payment was made.
 4. Send a mailed, faxed, or (preferably) e-mailed letter to the supplier (on which the NSC shall be copied):
- Stating that payment has been made, the date the payment was received, and the amount of said payment
 - Containing the following quoted verbiage:

“You must, within 30 calendar days of the date of this letter, obtain and submit to the NSC additional surety bond coverage in the amount of (insert the amount that the surety paid) so as to ensure that your total coverage equals or exceeds the required \$50,000 amount” (or higher if an elevated bond amount is involved due to a final adverse action). **“Failure to timely do so will result in the revocation of your Medicare enrollment.”**

“Additional surety bond coverage may be obtained by (1) adding to the amount of your existing surety bond so as to equal or exceed \$50,000, or (2) cancelling your current surety bond and securing a new \$50,000 surety bond. (Obtaining a separate (insert the amount the surety paid) surety bond is impermissible.) In either case, the effective date of the additional coverage must be on or before the date that you submit the additional coverage to the NSC.”

If the NSC does not receive the additional bond coverage within this 30-day period, it shall revoke the DMEPOS supplier’s Medicare enrollment under § 424.535(a)(1) enrollment in accordance with existing procedures. (The effective date of revocation shall be the date on which the DME MAC received payment from the surety.) It is important that the NSC (1) monitor the supplier’s surety bond status upon receiving a copy of the DME MAC’s letter to the supplier and (2) take prompt action against the supplier (consistent with existing procedures) if the supplier does not secure and timely submit the required additional coverage.

B. No Payment of the Claim is Made

If the surety fails to make any payment within the aforementioned 30-day timeframe, the DME MAC shall:

1. Continue collection efforts as outlined in Pub. 100-06, chapter 4;
2. No later than 14 days after the 30-day period expires, contact the surety via e-mail or telephone to ascertain the reason for non-payment. Only one contact is necessary. A voice mail message may be left. The contractor shall document any attempts to contact the surety by telephone and the content of any resultant conversations with the surety.
3. No later than 14 days after Step 2 has been completed – and if full payment still has not been received -- send the letter found in Section 10.7.16 of this chapter.
4. Include information relating to the surety's non-payment in the report outlined in section 10.2.5(A)(3)(o)(ii).

C. Partial Payment of the Claim is Made

If the surety pays part of the claim within the 30-day period and a balance is still due and owing, the DME MAC shall do the following:

1. Continue collection efforts as outlined in Pub. 100-06, chapter 4;
 2. No later than 14 days after the 30-day period expires, contact the surety via e-mail or telephone to ascertain the reason for the partial non-payment. Only one contact is necessary. A voice mail message may be left. The contractor shall document any attempts to contact the surety by telephone and the content of any resultant conversations with the surety.
 3. No later than 14 days after Step (ii) has been completed – and if full payment still has not been received -- send the letter found in Section 10.7.16 of this chapter.
 4. Include information relating to the surety's partial non-payment in the report identified in 10.2.5(A)(3)(o)(iii).
 5. No later than 10 calendar days after the partial payment was made:
- Update all applicable records to reflect that partial payment was made. (Payment from the surety shall be treated as payment from the supplier for purposes of said record updates.)
 - Send a mailed, faxed, or (preferably) e-mailed letter to the supplier (on which the NSC shall be copied):

- Stating that partial payment was made, the date the payment was received, and the amount of said payment
- Containing the following quoted verbiage:

“You must, within 30 calendar days of the date of this letter, obtain and submit to the NSC additional surety bond coverage in the amount of (insert the amount that the surety paid) so as to ensure that your total coverage equals or exceeds the required \$50,000 amount” (or higher if an elevated bond amount is involved due to a final adverse action). **“Failure to timely do so will result in the revocation of your Medicare enrollment.”**

“Additional surety bond coverage may be obtained by (1) adding to the amount of your existing surety bond so as to equal or exceed \$50,000, or (2) cancelling your current surety bond and securing a new \$50,000 surety bond. (Obtaining a separate (insert the amount the surety paid) surety bond is impermissible.) In either case, the effective date of the additional coverage must be on or before the date that you submit the additional coverage to the NSC.”

If the NSC does not receive the additional bond coverage within this 30-day period, it shall revoke the DMEPOS supplier’s Medicare enrollment under §424.535(a)(1) in accordance with existing procedures. (The effective date of revocation shall be the date on which the DME MAC received payment from the surety.) It is important that the NSC (1) monitor the supplier’s surety bond status upon receiving a copy of the DME MAC’s letter to the supplier and (2) take prompt action against the supplier (consistent with existing procedures) if the supplier does not secure and timely submit the required additional coverage.

D. Successful Appeal

If the DMEPOS supplier successfully appeals the CMP or assessment and the surety has already made payment, CMS will – within 30 days of receiving notice of the successful appeal - notify the surety via letter of the successful appeal and repay the surety.

5. Reporting Requirements

- DME MACs shall compile a report on a quarterly basis in the format prescribed in existing CMS directives. The report will capture the following elements:
- Number of account receivables (debts) reviewed for possible surety bond letter development
- Number of debts sent to the surety for recovery

- Amounts recovered directly from sureties (1) during the quarter in question, and (2) since March 3, 2009 (that is, the total/cumulative amount collected since the beginning of the surety bond collection process)
- Amounts paid by suppliers after the debt was referred to the surety for collection. The report shall include the (1) amount for the quarter in question and (2) total/cumulative amount since March 3, 2009.
- Names of suppliers and NSC numbers for which letters were sent to the surety and/or surety bond recoveries were received
- Names of suppliers on whose surety bond(s) the surety made payment in the last quarter and to whom the DME MAC consequently sent notice to the supplier that it must obtain additional surety bond coverage to reach the \$50,000 threshold.
- Names and addresses of sureties that have failed to make payment within the quarterly period. For each instance of non-payment, the report shall identify (a) the amount that was requested, (b) the amount that was paid (if any), (3) the name and tax identification number of the supplier in question, and (4) the reason the surety did not pay (to the extent this can be determined).

The quarterly reports shall encompass the following time periods: January through March, April through June, July through August, and September through December. Reports shall be submitted to the Provider Enrollment & Oversight Group (with a copy to the MAC COR) --- via the following e-mail address: XXXXXXXX@cms.hhs.gov --- by the 10th day of the month following the end of the reporting quarter. Information on surety collections shall be reported once for each demand letter. That action shall be reported only when the collection process has been fully completed for that specific identified overpayment, which may be comprised of multiple claims. For example, suppose the surety was sent a letter in December but its payment was not received until January. That action would be documented in the report encompassing the months of January, February, and March.

B. Indian Health Services (IHS) Facilities' Enrollment as DMEPOS Suppliers

1. Background

The National Supplier Clearinghouse (NSC) shall enroll IHS facilities as DMEPOS suppliers in accordance with (a) the general enrollment procedures cited in chapter 10, (b) the statement of work contained in the NSC contract with Medicare, and (c) the special procedures cited in this section.

For enrollment purposes, Medicare recognizes two types of IHS facilities: (1) facilities wholly owned and operated by the IHS, and (2) facilities owned by the IHS but tribally operated or totally owned and operated by a tribe. CMS will provide the NSC with a list of IHS facilities that distinguishes between these two types.

On the list, the NSC shall use the column entitled, “FAC OPERATED BY”, for this purpose.

2. Enrollment

The provider/supplier shall complete the Form CMS-855S in accordance with the instructions shown therein.

Facilities that are:

- Totally owned and operated by the IHS are considered governmental organizations. An Area Director of the IHS must sign section 15 of the Form CMS–855S, be listed in section 9 of the form, and sign the letter required under section 8 of the form that attests that the IHS will be legally and financially responsible in the event there is any outstanding debt owed to CMS.
- Tribally operated are considered tribal organizations. Section 15 of the Form CMS–855S must be signed by a tribal official who meets the definition of an “authorized official” under 42 CFR § 424.502. The individual must also be listed in section 9 of the form, and must sign the letter required under section 8 of the form that attests that the tribe will be legally and financially responsible in the event there is any outstanding debt owed to CMS.

3. Supplier Standards, Exceptions and Site Visits

All IHS facilities, whether operated by the IHS or a tribe:

- Shall meet all required standards, with the exception of:
- The comprehensive liability insurance requirements under 42 CFR 424.57(c)(10).
- The requirement to provide State licenses for their facility/business. For example, if the DMEPOS supplier indicates on its application that it will be providing hospital beds and is located in a State that requires a bedding license, such licensure is not required. However, if it provides a DMEPOS item that requires a licensed professional in order to properly provide the item, it shall provide a copy of the professional license. The licensed professional can be licensed in any State or have a Federal license (e.g., a pharmacy does not need a pharmacy license, but shall have a licensed pharmacist).
- Shall, like all other DMEPOS suppliers, undergo site visits in accordance with Section 10.6.20(A) and 10.6.20(B) of this chapter. (This includes all hospitals and pharmacies enrolling as DMEPOS suppliers.)

4. Provider Education for IHS Facilities

The NSC shall ensure that its Web site includes the information contained in this section 10.2.5(B) that is specific to enrollment of IHS facilities (whether operated by the IHS or a tribe).

5. Specialty Codes

The NSC shall apply the specialty code A9 (IHS) to all IHS enrollments (whether operated by the IHS or a tribe). However, the specialty code A9/A0 shall be applied to facilities that are IHS/tribal hospitals.

Other specialty codes should be applied as applicable (e.g., pharmacies).

C. Pharmacies' Enrollment as DMEPOS Suppliers

Refer to 10.2.2(D) for a discussion of pharmacy enrollment via the Form CMS-855B (i.e., pharmacy not enrolling as a DMEPOS supplier).

1. Compliance Standards for Pharmacy Accreditation

The National Supplier Clearinghouse (NSC) shall not require that a pharmacy be accredited as a condition of enrollment before January 1, 2011.

The NSC-Medicare Administrative Contractor (MAC) shall determine which enrolled suppliers are pharmacies that are not accredited and who will be enrolled for 5 calendar years prior to January 1 of the next calendar year. The NSC-MAC shall then send a notice of revocation by January 10, 2011, to all enrolled pharmacies that are not accredited and who will not be enrolled for 5 calendar years as of January 1, 2011.

The NSC-MAC shall prepare a letter which enables all individually enrolled practice locations of pharmacies who have been enrolled for 5 calendar years prior to January 1, 2011, to attest that they are exempt from the requirement to be accredited because their total durable medical equipment, prosthetics orthotics and supplies (DMEPOS) billings subject to accreditation are less than 5 percent of their total pharmacy sales, as determined based upon the total pharmacy sales of the pharmacy for the previous 3 calendar or fiscal years. The letter shall cite that the attestation requires the signature of the authorized or delegated official of the entity. The authorized and delegated officials are defined in Section 15, of the Medicare Enrollment Application (CMS-855S), and as described in the internet enrollment application version of the Provider Enrollment, Chain and Ownership System (PECOS). Before mailing the letters, the NSC-MAC shall obtain NSC project officer approval of the letter. The mailing shall be in the form of an endorsement letter with an enclosed stamped self-addressed envelope. The mailing should be performed between October 1, 2010 and October 31, 2010. For pharmacies with more than one practice location, the letters shall cite the need for each individually enrolled practice location to attest that they are exempt from the accreditation requirements. New locations of enrolled chain pharmacies shall not be considered to have been enrolled for 5 calendar years. Pharmacies that have had a change of ownership in the prior 5 years which resulted in a change in their legal business entity, including a change in their tax identification number (TIN), shall not

qualify for an attestation accreditation exemption and therefore shall not be sent the attestation letter.

The NSC-MAC shall review the attestations received from pharmacies. Pharmacies that properly signed the attestation letter shall be given an accreditation status of exempt. The NSC shall make attempts to assist and follow-up with pharmacy suppliers that have not submitted or properly completed their attestations. The NSC-MAC shall send a notice of revocation by January 10, 2011, to all enrolled pharmacies who were sent an attestation letter and have not properly completed it as of the date of the notice of revocation. The notice of revocation shall cite that the revocation is for a lack of required accreditation.

Between April 1, 2011 and April 30, 2011, the NSC-MAC shall compile a sample listing of at least 10 percent of the pharmacies that have submitted an NSC accepted attestation exempting them from accreditation. The NSC-MAC shall develop a letter to be sent to pharmacies that will be audited to determine if their accreditation exemption attestations are correct. The letter shall request submission of evidence substantiating that the validity of the pharmacy supplier's attestation. At a minimum, requested materials for this evidence shall include a certification by an accountant on behalf of the pharmacy or the submission of tax returns filed by the pharmacy during the relevant periods. The NSC-MAC shall obtain NSC project officer approval of the letter. Within 45 days after project officer approval of the letter the NSC-MAC shall mail a copy of the letter to the random sample of pharmacies which claimed exemption through an attestation. The NSC-MAC shall determine the acceptability of the replies received in response to the audit verification random sample mailing. The NSC shall use DMEPOS billing data for only products and services requiring accreditation to assist in the determination. The NSC shall make attempts to assist and follow-up with pharmacy suppliers that have not submitted or properly completed their audit verifications. The NSC-MAC shall consult with the NSC project officer in cases where they are uncertain as to the acceptability of the supplier's response to the audit request. By June 30, 2011, the NSC-MAC shall send a notice of revocation to all enrolled pharmacies that were sent an audit verification letter who did not submit satisfactory evidence that they were in compliance with the requirements to obtain an accreditation exemption. The notice of revocation shall cite that the revocation is for a lack of required accreditation.

The NSC-MAC shall follow the procedures shown above concerning issuance of attestation letters and audit survey letters for all succeeding years after they have been performed for the first time.

10.2.6 - Medicare Diabetes Prevention Program (MDPP) Suppliers (Rev. 10138; Issued: 05-15-2020; Effective: 06-16-2020; Implementation: 06-16-2020)

A. General Background Information

The Diabetes Prevention Program (DPP) is a structured lifestyle intervention that includes dietary coaching, lifestyle intervention, and moderate physical activity, all with the goal of preventing the onset of diabetes in individuals who are pre-diabetic. The clinical intervention

consists of 16 intensive “core” sessions of a curriculum in a group-based, classroom-style setting that provides practical training in long-term dietary change, increased physical activity, and behavior change strategies for weight control. After the 16 core sessions, less intensive monthly follow-up sessions help ensure that the participants maintain healthy behaviors. The primary goal of the intervention is lowering the progression to type 2 diabetes, measured using a proxy of at least 5 percent average weight loss among participants.

The Center for Medicare & Medicaid Innovation (CMMI) first tested the DPP program in the Medicare population through a Round One Health Care Innovation Award (HCIA). In March 2016, Department of Health and Human Services (HHS) announced that the Centers for Medicare & Medicaid Services (CMS) Office of the Actuary (OACT) certified the pilot DPP model as a cost savings program that reduced net Medicare spending. The Secretary then determined that the program demonstrated the ability to improve the quality of patient care without limiting coverage or benefits. Together, these determinations fulfilled CMMI’s model expansion requirements of Section 1115A of the Social Security Act.

As a result, CMMI expanded the initial HCIA model test into a national Medicare DPP (MDPP) model where organizations furnish MDPP services to beneficiaries with an indication of pre-diabetes for one year, and individuals who meet certain performance goals may continue eligibility to receive MDPP services through monthly ongoing maintenance sessions for up to an additional year.

B. MDPP Suppliers Eligibility and Enrollment Requirements

An entity or individual who wishes to furnish MDPP services –to Medicare beneficiaries must enroll as an “MDPP supplier” via the Form CMS-20134. Such suppliers must meet the following requirements:

- Have MDPP preliminary recognition, as defined at 42 CFR 424.205 or full recognition as determined by the Center for Disease Control and Prevention’s (CDC) Diabetes Prevention Recognition Program (DPRP)
- Obtained and maintained valid TIN and NPI at the organizational level
- Passed application screening at a high categorical risk level per § 424.518(c) upon initial enrollment and revalidate at moderate categorical risk level per § 424.518(b), and
- Complies with the supplier standards.

As noted above, MDPP supplier applicants do not require any licensure, accreditation, or certificates to be eligible to enroll as an MDPP supplier. Rather, the CDC administers the curriculum for the DPP and monitors organization’s fidelity to and success with furnishing the services. Thus, organizations with preliminary or full recognition from the CDC’s DPRP indicate that they are prepared to deliver MDPP services.

As a part of the expanded CMMI model, CMS will only accept in-person MDPP suppliers to enroll into Medicare. Though an entity may furnish a select number of virtual MDPP make up sessions to a beneficiary (no more than 4 per beneficiary over the entire period of MDPP services), they would still be considered in-person MDPP suppliers.

C. MDPP Supplier Standards

All MDPP suppliers must comply with MDPP supplier standards in order to obtain and retain Medicare billing privileges. Consistent with 42 CFR §424.205(d), each MDPP Supplier must certify on its Form CMS-20134 enrollment application that it meets and will continue to meet the following standards and all other requirements:

- Must have and maintain MDPP preliminary recognition, or full CDC DPRP recognition.
- Must not currently have its billing privileges terminated or be excluded by a state Medicaid agency.
- Must not permit MDPP services to be furnished by or include on its roster any individual coach who meets ineligibility criteria.
- Must maintain at least one administrative location on an appropriate site. All administrative locations, must be reported on their CMS-20134 form and may be subject to site visits.
- Must update this enrollment application within 30 days for any changes of ownership, changes to the coach roster, and final adverse legal action history and update all other changes within 90 days.
- Must maintain a primary business telephone that is operating at administrative locations or directly where services are furnished. The associated telephone number must be listed with the name of the business in public view.
- Must not convey or reassign a supplier billing number.
- Must not deny an MDPP beneficiary access to MDPP services during the MDPP benefit period, including conditioning access to MDPP services on the basis of an MDPP beneficiary's weight, health status, or achievement of performance goals, with certain exemptions.
- Must offer MDPP beneficiaries the entirety of the MDPP benefit to which they are eligible.
- Must not, nor may other individuals or entities performing functions or services related to MDPP on the MDPP supplier's behalf, directly or indirectly commit any act or omission, or adopt any policy that coerces or otherwise influences an MDPP beneficiary's decision to begin accessing MDPP services, or change to a different MDPP supplier specifically.
- Must disclose detailed information about the MDPP benefit to each beneficiary to whom it furnishes MDPP services before the initial core session is furnished, including the set of services, eligibility requirements, the once per lifetime nature of the MDPP benefit, and these standards.
- Must answer MDPP beneficiaries' questions about MDPP services and respond to MDPP related complaints. An MDPP supplier must implement a complaint resolution protocol and maintain documentation of all beneficiary contact regarding such complaints, including the name and Medicare Beneficiary Identifier of the beneficiary, a summary of the complaint, related correspondences, notes of actions taken, and the names and/or NPIs of individuals who took such action on behalf of the MDPP supplier. This information must be kept at each administrative location and made available to CMS or its contractors upon request.
- Must maintain a crosswalk file which indicates how participant identifications for the purposes of CDC performance data correspond to corresponding beneficiary health insurance claims numbers or Medicare Beneficiary Identifiers for each MDPP beneficiary. The MDPP supplier must submit the crosswalk file to CMS or its contractor.
- Must submit performance data for MDPP beneficiaries who attend ongoing maintenance sessions with data elements consistent with the CDC's DPRP Standards for data elements required for the core benefit.
- Must allow CMS or its agents to conduct onsite inspections or recordkeeping reviews in order to ascertain the MDPP supplier's compliance with these standards, as well as

documentation requirements.

The CMS will notify any contractor when an MDPP supplier within their jurisdiction has moved from preliminary or full recognition down to pending, and therefore no longer maintains eligibility for an MDPP supplier.

For those suppliers that no longer have a valid recognition level to maintain their MDPP supplier enrollment, the contractor shall take the necessary steps to revoke the supplier's billing privileges.

Violations of such standards are determined as non-compliance, and the associated enrollment denial and revocation authorities would apply.

10.2.7 - Opioid Treatment Programs

(Rev. 10674; Issued:03-19-21 ; Effective:01-04-21 ; Implementation:01-29-21)

A. Legislative and Regulatory Background

The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (hereafter referenced as the "SUPPORT Act") was designed to alleviate the nationwide opioid crisis by: (1) reducing the abuse and supply of opioids; (2) helping individuals recover from opioid addiction and supporting the families of these persons; and (3) establishing innovative and long-term solutions to the crisis. Section 2005 of the SUPPORT Act attempted to fulfill these objectives, in part, by establishing a new Medicare benefit category for opioid treatment programs (OTPs).

An OTP is currently defined in 42 CFR § 8.2 as a program or practitioner engaged in opioid treatment of individuals with an opioid agonist treatment medication registered under 21 U.S.C. § 823(g)(1). There are three overarching (but not exclusive) requirements that an OTP must meet in order to bill for OTP services:

1. Accreditation

The OTP must have a current, valid accreditation by an accrediting body or other entity approved by the Substance Abuse and Mental Health Services Administration (SAMHSA), the federal agency that oversees OTPs. The accreditation process includes, but is not limited to, an accreditation survey, which involves an onsite review and evaluation of the OTP to determine compliance with applicable federal standards. There are currently six SAMHSA-approved accreditation bodies.

2. Certification

The OTP must have a current, full, valid certification by SAMHSA for such a program. The prerequisites for certification (as well as the certification process itself) are addressed in 42 CFR § 8.11 and include, but are not restricted to, the following:

- Current and valid accreditation (described in subsection (A)(1) above)
- Adherence to the federal opioid treatment standards described in 42 CFR § 8.12
- Compliance with all pertinent state laws and regulations, as stated in § 8.11(f)(1)

Under 42 CFR § 8.11(a)(3), certification is generally for a maximum 3-year period, though this may be extended by 1 year if an application for accreditation is pending. SAMHSA may revoke or suspend an OTP's certification if any of the applicable grounds identified in 42 CFR § 8.14(a) or (b), respectively, exist.

3. Enrollment

The SUPPORT Act also required that an OTP be enrolled in the Medicare program under section 1866(j) of the Act in order to bill and receive payment from Medicare for opioid use disorder treatment services.

In the Calendar Year (CY) 2020 Physician Fee Schedule final rule (published in the **Federal Register** on November 15, 2019 (84 FR 62567)), CMS established a new 42 CFR § 424.67 containing requirements that OTPs must meet and continually adhere to in order to enroll (and remain enrolled) in Medicare effective January 1, 2020. Since this latter date, OTPs have enrolled in Medicare consistent with 42 CFR § 424.67 and the general provider enrollment requirements of 42 CFR Part 424, subpart P (42 CFR § 424.500-570). This section 10.2.7 outlines the specific enrollment policies associated with OTP enrollment.

B. OTP Enrollment Process

The instructions in this section 10.2.7(B) are in addition to, and not in lieu of, those in CMS Pub. 100-08, Program Integrity Manual (PIM), chapter 10. To the extent there are conflicting instructions, the policies in this section 10.2.7 shall take precedence.

1. Applicable Form CMS-855

As of November 16, 2020, OTPs may enroll (and remain enrolled) via the Form CMS-855B or the Form CMS-855A, but not both. Some OTPs currently enrolled via the Form CMS-855B may accordingly seek to change their enrollment to a Form CMS-855A. To ensure that the OTP is at no time enrolled under both Form CMS-855 application types, the contractor shall do the following:

- Upon receipt of an initial Form CMS-855A or Form CMS 855B from an OTP, the contractor shall confirm that the OTP is not currently enrolled as such via another Form CMS-855 application type. (For example, if the contractor receives an initial Form CMS-855A from an OTP, the contractor shall verify that the OTP is not already enrolled via the Form CMS-855B.)
- If the contractor determines that the OTP is not already enrolled as such, the contractor shall process the application normally.
- If, however, the contractor determines that the OTP is already enrolled as such via a different Form CMS-855 application type, the contractor shall verify with an authorized or delegated official of the OTP (by telephone or e-mail) that the OTP is changing its enrollment from a Form CMS-855B to a Form CMS-855A (or vice versa). The OTP in this situation is not required to submit a Form CMS-855 application to voluntarily terminate its prior enrollment.

The Form CMS-855B has been updated to add "Opioid Treatment Program" as a listed provider type. For the Form CMS-855A (at least until that form is updated) and the 7/11 version of the

Form CMS-855B, the OTP shall check the “Other” box in Section 2 and state “Opioid Treatment Program.”

An entity that is enrolling or is already enrolled in Medicare as another provider or supplier type may also seek enrollment as an OTP. It must, however, submit a separate Form CMS-855 application to do so; it cannot enroll or be enrolled as an OTP and another provider/supplier type via the same enrollment.

Note that the policies in this section 10.2.7 regarding an OTP’s transition from a Form CMS-855B enrollment to a Form CMS-855A enrollment (or vice versa) only apply if the OTP is doing so in the same state in which it is currently enrolled as an OTP. If an OTP is enrolling under a different Form CMS-855 in a state different from that in which it is currently enrolled (e.g., a Form CMS-855B enrolled OTP in State X is enrolling via the Form CMS-855A in State Y), it is considered a brand new enrollment (and not merely a “switch” in OTP enrollment type); this would thus require, for instance, moderate or high-level screening as opposed to limited screening (as discussed further in section 10.2.7(B)(3) below).

1. Applicable Fee

An OTP is an “institutional provider” under 42 CFR § 424.502 and thus is required to pay an application fee pursuant to 42 CFR § 424.514. The contractor shall follow the application fee procedures outlined in chapter 10 of the PIM. A fee is required even when the OTP is changing its enrollment from a Form CMS-855B to a Form CMS-855A, or vice versa.

2. Categorical Screening

Consistent with 42 CFR § 424.518, the contractor shall categorically screen OTP applications as follows:

- a. Newly enrolling OTPs that **are not** changing their enrollment from a Form CMS-855B to a Form CMS-855A, or vice versa -
 - If the OTP has not been fully and continuously certified by SAMHSA since October 24, 2018, the contractor shall conduct high-risk level categorical screening.
 - If the OTP has been fully and continuously certified by SAMHSA since October 24, 2018, the contractor shall conduct moderate-risk level categorical screening.
- b. Newly enrolling OTPs that **are** changing their enrollment from a Form CMS-855B to a Form CMS-855A, or vice versa - The contractor shall conduct limited-risk level categorical screening if the OTP had previously completed, as applicable, the moderate or high-risk level screening as part of its initial enrollment. Otherwise, moderate or high-risk level screening (as applicable under § 424.518) shall be conducted.
- c. Revalidating OTPs – The contractor shall conduct moderate-risk level categorical screening.
- d. Practice Location Addition – The contractor shall conduct moderate-risk level categorical screening (i.e., site visit of the new location consistent with the procedures outlined in this chapter 10).

3. Confirmation of Certification

When processing OTP initial applications (including those involving a change in Form CMS-855 application type) and revalidation applications, the contractor shall confirm and record in PECOS the OTP's SAMHSA certification status as follows:

- a. Review the OTP directory at: <https://dpt2.samhsa.gov/treatment/directory.aspx>. The OTP's certification must be full, current, and valid. ("Provisional" certification status is not acceptable.) The OTP's SAMHSA certificate (and the OTP's identification in the SAMHSA directory) need not have the exact same legal business name as that on the OTP's IRS document, though the contractor shall develop for clarification if it has questions as to whether the OTP on the application and in the directory are truly the same.
- b. Verify that each location listed on the Form CMS-855 is separately and uniquely certified.
- c. Enter into PECOS the OTP's relevant certification data obtained from the aforementioned OTP directory. This includes: (1) the OTP number; and (2) the certification effective date (which can be obtained from the OTP's renewal letter). The certification effective date is the date on which SAMHSA acknowledged notification from the accrediting organization and can be verified by reviewing the OTP's renewal letter information in the database. (The contractor need not obtain a copy of the letter from the OTP.)

The expiration date must be obtained via the SAMHSA operating certificate for the location in question; the OTP should submit said certificate with its application.

Irrespective of whether the OTP reported the data described in (4)(c) on the Form CMS-855, the contractor shall use the information in the OTP directory for purposes of data entry.

4. OTP Managing Employees

As with all enrolling providers and suppliers, the OTP must disclose all of its managing employees in Section 6 of the Form CMS-855. Such managing employees must include the OTP's medical director and program sponsor, which the OTP must have pursuant to 42 CFR §§ 8.12(b) and §§ 424.67(b)(5). The contractor shall verify that the medical director is a validly licensed physician or psychiatrist; he/she must be licensed by the state in which the OTP's primary practice location is situated. The contractor may develop with the OTP for any information it needs (and via any manner it chooses) to verify the person's licensure. If the contractor determines that the individual is not appropriately licensed, it shall contact its PEOG BFL for guidance.

The OTP must submit a copy of the organizational diagram required under Section 5 of the Form CMS-855 even if it merely changing its enrollment type from a Form CMS-855B to a Form CMS-855A (or vice versa).

5. OTP Personnel

i. Regulatory Background

Section 424.67 contains several important provisions concerning OTP personnel. These include:

- Completion of Attachment/Supplement (§ 424.67(b)(1)(i)) - Requires the OTP to maintain and submit to CMS (via the applicable Form CMS-855 supplement or attachment) a list of all physicians, other eligible professionals, and pharmacists (regardless of whether the individual is a W-2 employee of the OTP) who are legally authorized to prescribe, order, or dispense

controlled substances on the OTP's behalf. The list must include the individual's (1) first and last name and middle initial, (2) social security number, (3) NPI, and (4) license number (if applicable).

- Felony Convictions (§ 424.67(b)(6)(i)(A)) - The OTP must not employ or contract with a prescribing or ordering physician or eligible professional or with any individual legally authorized to dispense narcotics who, within the preceding 10 years, has been convicted of a federal or state felony that CMS deems detrimental to the best interests of the Medicare program and its beneficiaries. The applicable felonies are based on the same categories of detrimental felonies (as well as case-by-case detrimental determinations) found at § 424.535(a)(3).

It is immaterial whether the individual is (1) currently dispensing narcotics at or on behalf of the OTP or (2) a W-2 employee of the OTP.

- Revoked/Preclusion List (§ 424.67(b)(6)(ii)) - The OTP must not employ or contract with any personnel (regardless of whether the individual is a W-2 employee of the OTP) who is (1) revoked from Medicare under § 424.535 or any other applicable section in Title 42 or (2) on the preclusion list.
- State Board Action (§ 424.67(b)(6)(iii)) - The OTP must not employ or contract with any personnel (W-2 or otherwise) who has a prior adverse action by a state oversight board (including, but not limited to, a reprimand, fine, or restriction) for a case involving patient harm that CMS deems detrimental to the best interests of the Medicare program and its beneficiaries.

ii. Attachment and Verification

Attachment 3 of the Form CMS-855B collects information on the individuals described in § 424.67(b)(1)(i) above. (The Form CMS-855A will eventually be updated to include a similar attachment, after which OTPs completing that form will have to submit the attachment.) OTPs submitting the Form CMS-855B (either the current/revised/new 07/20 version or the prior 07/11 version) must complete this attachment as described in (and subject to) (ii)(A) below and, once enrolled, report any changes to the information thereon (e.g., new or deleted prescribers) consistent with 42 CFR § 424.516(e).

Irrespective of the type of transaction involved (e.g., initial, revalidation, change of information), the contractor shall accept from the OTP:

- The revised version of the Form CMS-855B (which includes the aforementioned OTP attachment) beginning January 4, 2021.
- The prior (07/11) version of the Form CMS-855B through March 31, 2021. (Any such application received by the contractor after March 31, 2021 shall be returned to the OTP consistent with the instructions in this chapter and other applicable CMS guidance.)

Pursuant to the foregoing, the contractor shall adhere to the following policies and instructions in this section (6)(ii).

(A) When to Submit Attachment

(1) General Principles

The OTP need only submit the attachment for the first time as part of (i) an initial Form CMS-855B enrollment, (ii) a Form CMS-855B revalidation (periodic or off-cycle), or (iii) a change from a Form CMS-855A enrollment to a Form CMS-855B enrollment. (For purposes of this requirement, the term “Form CMS-855B” includes the 07/20 version and the 07/11 version (the latter only through March 31, 2021, however).) The OTP is not required to complete it for the first time as part of a change of information request. Consider the following examples:

- Example 1 - Smith OTP enrolled in Medicare via the Form CMS-855B in June 2020, prior to the Form CMS-855B being revised to include the attachment. Smith submits a change request in June 2021 to add a new billing agency. Smith need not complete the attachment at this time because Smith’s application does not fall within any of the three categories in (A)(i) through (iii) above.
- Example 2 - Using Example 1, suppose Smith submitted a Form CMS-855B revalidation application (rather than a change of information) in June 2021. Smith would have to complete the attachment at that time.
- Example 3 - Again using Example 1, suppose Smith submitted a Form CMS-855A in March 2021 to change its enrollment from a Form CMS-855B. No attachment need be completed because the Form CMS-855A lacks an attachment and because no category in (A)(i) through (iii) above applies.
- Example 4 - Again using Example 1, assume Smith in August 2020 hired two pharmacists to dispense controlled substances on its behalf. Smith would neither have to report these persons on the attachment nor complete the attachment in full, for no category in (A)(i) through (iii) above applies.
- Example 5 – Suppose Jones OTP submits an initial enrollment application on March 1, 2021 using the 07/11 version of the Form CMS-855B. The contractor may accept the application, but the latter must include the information on the attachment. (If a paper application is used, the OTP must take the attachment from the 07/20 version, complete it, and submit it with its 07/11 application.) If the OTP in this scenario fails to include the attachment, the contractor shall develop for it using the instructions in this chapter.
- Example 6 – Using Example 5, suppose Jones enrolled as an OTP in September 2020. It submits a change of information using the 07/11 version of the Form CMS-855B on February 15, 2021. Jones need not submit the OTP attachment with its change request because no category in (A)(i) through (iii) above applies.
- Example 7 – Using Example 6, assume Jones submitted its change request on April 15, 2021 rather than February 15. The contractor shall return the application because the 07/11 version is no longer in use; however, Jones need not submit the OTP attachment at that time because no category in (A)(i) through (iii) above applies.

(2) Submission When Not Required

Instances could occur where the OTP submits the Form CMS-855B attachment for the first time when it was not required to do so (i.e., no category in (6)(A)(i) through (iii) applies). The two most likely scenarios would involve: (a) a Form CMS-855A OTP application submission (e.g., initial, change request); or (b) a Form CMS-855B-enrolled OTP submitting a change request.

In the case of (a), the contractor shall not process the attachment and may either keep it in the provider file or return it to the OTP via the general procedures in this chapter for returning applications. Regardless of which of the latter two approaches the contractor takes, the contractor shall: (i) notify the OTP that the attachment was not processed; (ii) explain why; and (iii) state that the attachment will need to be submitted at a later time as determined by CMS. If the contractor elects to retain the attachment, the notification in (i)/(ii)/(iii) above may be given in any matter the contractor chooses.

For (b), the contractor shall process the attachment consistent with the instructions in this section (6)(ii).

(B) Owing/Managing Individuals - Notwithstanding (6)(ii)(A) above, any person otherwise required to be reported on the attachment must also be disclosed in Section 6 of the Form CMS-855B if he or she qualifies as a 5 percent or greater owner, managing employee, partner, etc. To illustrate, assume Dr. Jones prescribes controlled substances on the OTP's behalf. He is also a managing employee of the OTP. The OTP is initially enrolling in Medicare via the Form CMS-855B. Jones would have to be listed in Section 6 and on the attachment. If Jones left the OTP altogether, the OTP would have to report this in both Section 6 and the attachment; if Jones no longer prescribes drugs for the OTP but remains a managing employee, this would have to be reported via the attachment but not in Section 6.

(C) Timeframe for Changes - Additions/deletions/changes to the information in the attachment must be reported within 90 days of the change per 42 CFR § 424.516(e)(2).

(D) Missing Data - In general, the contractor shall develop (using the procedures outlined in this chapter) for any data that is missing or unverifiable on the attachment. (This includes individuals who the contractor learns (via any means) should be listed on the attachment but were not.) However, and with the exception of names and social security numbers, the contractor may forgo such development if the missing/unverifiable information can be located and validated via other means. This could include, for example: (i) the NPI of the individual (who is also a managing employee) is listed in Section 6 of the Form CMS-855B; or (ii) the person's license number can be obtained through PECOS.

Note that the specific processing exception addressed in (D) applies only to OTPs. Other processing exceptions applicable to other provider and supplier types (as well as to OTPs) can be found elsewhere in this chapter.

(E) Validation of Individuals on Attachment - The contractor shall review all individuals listed on the attachment against the MED and the SAM. (The contractor may combine this step with its check of the same individual if the latter is also listed in Section 6 of the form; it need not perform two separate reviews.) The contractor shall contact its PEOG BFL for further guidance if the contractor determines or learns during its screening that the individual:

- Is OIG excluded,
- Is debarred (per the SAM),
- Is on the preclusion list,
- Has one of the actions described in §§ 424.67(b)(6)(i)(A), 424.67(b)(6)(ii), or §§ 424.67(b)(6)(iii) above, or
- Does not meet applicable requirements to prescribe, order, or dispense controlled substances on the OTP's behalf.

In reviewing all individuals listed on the attachment (and absent a CMS directive to the contrary), the contractor is not required to perform any validation activities beyond those which it would ordinarily perform for persons listed in Section 6. (For example, the contractor need not research each person to determine (i) whether he/she is licensed, (2) what his/her license number is, or (3) whether he/she has ever had a fine imposed against him/her related to patient harm.)

(F) Multiple Locations and Off-Site – All persons who meet the requirements of § 424.67(b)(1)(i) must be listed on the OTP’s attachment regardless of where the individual is located (e.g., the primary practice location, one of the OTP’s multiple locations, his/her home, etc.) The central issue is whether the individual is authorized to act on the OTP’s behalf, not his/her location.

(G) Appropriate Attachment Sections

As there is no section on the Form CMS-855B attachment specific to prescribers, such persons should be listed in the “Ordering Personnel Identification” section rather than the “Dispensing Personnel Information” section. However, if the contractor determines that the prescriber was inadvertently listed in the “Dispensing” section, it need not require the OTP to move him/her to the “Ordering” section. In addition:

- If the person qualifies as both an ordering and dispensing individual but is only listed in one of the two sections of the attachment, the contractor need not require the OTP to list him/her in both.
- If the person qualifies as either an ordering or dispensing individual but is listed in the incorrect section (e.g., a dispenser is listed in the ordering section), the contractor need not require the OTP to move him/her to the other section.

iii. Person With Adverse Action But Need Not Be Listed on Attachment or in Section 6

There may be instances where the contractor learns (via any means) that an individual described in §§ 424.67(b)(6)(i)(A), 424.67(b)(6)(ii), or §§ 424.67(b)(6)(iii) has one of the actions described within those regulatory sections but was not required to be listed on the OTP’s application (either on the attachment or elsewhere on the application). Examples could include the following:

- A W-2 nurse has restrictions on her license due to a patient harm case
- A non-prescribing/non-ordering physician under contract is currently on the preclusion list
- A physician assistant employee is currently revoked from Medicare.

These individuals may not have met the criteria under § 424.67(b)(1)(i) to be reported on the attachment or the OTP may not have yet been required to submit the attachment (e.g., the OTP is enrolled via the Form CMS-855A.) Regardless, if the contractor becomes aware of such an individual, it shall contact its PEOG BFL for guidance.

7. Provider Agreement

i. Basic Requirement

To enroll (and remain enrolled) in Medicare as an OTP, the OTP must sign and adhere to the terms of the Form CMS-1561 Provider Agreement. (This is the same agreement signed by certified providers such as hospitals, hospices, and home health agencies. See 42 CFR Part 489,

Subparts A through E (as well as CMS Pub. 100-07, State Operational Manual) for general information on provider agreements.) Given this, the contractor shall verify that the OTP submitted a signed and dated Form CMS-1561 with its initial enrollment package. The provider agreement must be signed by an authorized or delegated official (as those terms are defined in § 424.502) of the OTP; the signature can be handwritten or digital. This form may be accepted via mail, fax, email, or document upload. The legal business name on the Form CMS-1561 must match that on the Form CMS-855.

If the OTP failed to submit the Form CMS-1561 as described in the previous paragraph, the contractor shall develop for the document (or any missing or inconsistent data thereon) consistent with the procedures outlined in chapter 10 of the PIM.

ii. Criteria for Inapplicability

The requirement to submit, sign, and date a new Form CMS-1561 does not apply if the OTP meets all of the following requirements: (1) the OTP is already enrolled as such in Medicare; (2) the OTP already has a valid Form CMS-1561 agreement in effect; and (3) the OTP is newly enrolling solely to change its existing Form CMS-855B enrollment to a Form CMS-855A, or vice versa.

8. Locations

An OTP may have multiple practice locations under a single enrollment so long as they all have the same legal business name and employer identification number. However, it may not split its locations between a Form CMS-855A enrollment and a Form CMS-855B enrollment. All locations must be under one enrollment. To illustrate, suppose an OTP is currently enrolled via the Form CMS-855B. It has four locations - W, X, Y, and Z. The OTP cannot keep W and X under its Form CMS-855B enrollment and switch Y and Z to a Form CMS-855A enrollment. It must retain all locations under the Form CMS-855B enrollment or move them all to a Form CMS-855A enrollment.

C. Approval

1. No State Agency or Regional Office (RO) Involvement

Unlike with many entities that complete the Form CMS-855A, there is no state agency or CMS RO involvement with OTP Form CMS-855A enrollments. Accordingly, no recommendations for approval or other type of referral need be made to the State or RO nor will the CMS RO send any tie-in notice to the contractor. Except as otherwise stated in this section 10.2.7, the application will be reviewed and handled entirely at the contractor level

2. Process of Approval

If the contractor determines that the OTP's application should be approved, it shall undertake the following:

- a. For Form CMS-855A applications only, request via PEMACReports@cms.hhs.gov that CMS assign a Form CMS-855A CCN to the enrollment. (This task is required even if the OTP is merely changing its existing enrollment from a Form CMS-855B to a Form CMS-855A.)

- b. As applicable (and except as stated in section (B)(7)(ii) above), send the Form CMS-1561 to PEMACReports@cms.hhs.gov for CMS to execute the signature on behalf of the Secretary. CMS will return the executed provider agreement within 3 business days. (The tasks in 2(a) and 2(b) can be completed via the same e-mail.)
- c. As applicable, send a copy of the executed provider agreement to the OTP along with the enrollment approval letter. (The contractor shall retain the original provider agreement.)

3. Effective Date of Billing

For newly enrolling OTPs that are not changing their enrollment from a Form CMS-855B to a Form CMS-855A (or vice versa), the contractor shall apply the effective date policies outlined in 42 CFR §§ 424.520(d) and 424.521(a) and explained in chapter 10 of the PIM.

For newly enrolling OTPs that are changing their enrollment from a Form CMS-855B to a Form CMS-855A (or vice versa), the contractor shall apply to the new/changed enrollment the same effective date of billing that was applied to the OTP's initial/former enrollment. (See 42 CFR § 424.67(c)(2).) To illustrate, suppose an OTP initially enrolled via the Form CMS-855B in 2020. The effective date of billing was April 1, 2020. Wishing to submit an 837I claim form for the services it has provided since April 1, 2020 the OTP elects to end its Form CMS-855B enrollment and enroll via the Form CMS-855A pursuant. It successfully does the latter in March 2021. Under § 424.67(c)(2), the billing effective date of the Form CMS-855A enrollment would be retroactive to April 1, 2020 (though the time limits for filing claims found in § 424.44 would continue to apply).

- 4. In cases where the OTP is changing its Form CMS-855 enrollment type, the contractor shall do the following:
 - a. End-date/deactivate the prior enrollment effective: (1) the date following that on which the OTP submitted its last claim under its prior enrollment; or (2) the prior enrollment's effective date of billing if no claims were submitted under the prior enrollment. The PECOS L & T basis shall be "Voluntary Termination." The deactivation reason shall be "Voluntary withdrawal: Applicant voluntarily withdrew from Medicare program."
 - b. Notify the OTP in the approval letter that the OTP's prior enrollment has been end-dated/deactivated and specify said end-date.

10.2.8 - Providers/Suppliers Not Eligible to Enroll

(Rev. 10481; Issued: 11-18-20; Effective: 11-16-20; Implementation: 11-20-20)

Below is a list of individuals and entities that frequently attempt to enroll in Medicare, but are not eligible to do so. This list is not an all-inclusive list. If the contractor receives an enrollment application from any of these individuals or entities, the contractor shall deny the application, with the exception of entities eligible to enroll using the Form CMS-20134, which is specific to the furnishing of MDPP services. An assisted living facility, for example, that also provides the DPP and is eligible to enroll as an MDPP supplier may enroll through the CMS-20134, however, this enrollment only pertains to the rendering of MDPP services.

- Acupuncturist
- Assisted Living Facility
- Birthing Center
- Certified Alcohol and Drug Counselor
- Certified Social Worker
- Drug and Alcohol Rehabilitation Counselor
- Hearing Aid Center/Dealer
- Intern (Graduate Medical Education)
- Licensed Alcoholic and Drug Counselor
- Licensed Massage Therapist
- Licensed Practical Nurse
- Licensed Professional Counselor
- Marriage Family Therapist
- Master of Social Work
- Medicare Beneficiaries
- Mental Health Counselor
- National Certified Counselor
- Naturopath
- Occupational Therapist Assistant
- Physical Therapist Assistant
- Registered Nurse
- Speech and Hearing Center
- State Medicaid Agency

State Medicaid agencies do not have a National Provider Identifier and are not eligible to enroll in the Medicare program. If a Medicaid State agency is enrolled or seeks enrollment as a provider or supplier in the Medicare program, the contractor shall deny or revoke its Medicare billing privileges using, respectively, §424.530(a)(5) (denials) and § 424.535(a)(3) (revocations) as the basis.

- Substance Abuse Facility

10.3 – Medicare Enrollment Forms: Information and Processing (Rev. 10524; Issued: 12-17-20; Effective: 11-13-20; Implementation: 11-13-20)

Sections 10.3.1, 10.3.2 and 10.3.3 of this chapter provide guidance and information regarding processing of all provider enrollment forms.

10.3.1 - CMS-855 Series Enrollment Forms: Information and Processing (Rev. 10524; Issued: 12-17-20; Effective: 11-13-20; Implementation: 11-13-20)

Each CMS-855 Series form is used to enroll a specific provider or supplier type for a specific purpose.

This section discusses various data elements on the CMS 855 Forms. Not every data element on the forms is discussed in these sections; only those elements that warrant additional instructions are mentioned. Information herein supports and does not supplant the instructions and information within the applications themselves. Information herein shall not supersede federal regulations concerning Medicare provider screening and enrollment.

Regardless of whether the data element in question is discussed in this section, the contractor shall adhere to all instructions in this chapter 10 in terms of the collection, processing, and verification of all data elements on the Form CMS-855 applications, unless stated otherwise in this chapter or in another CMS directive.

For purposes of these sections, and unless otherwise indicated, the term “approval” includes recommendations for approval.

If the contractor needs additional information concerning forms or processing forms, the contractor should contact its PEOG BFL.

A. CMS-855A – Medicare Enrollment Application for Institutional Providers

This application should be completed by institutional providers (e.g., hospitals) that will furnish Medicare Part A services to beneficiaries.

1. Sections of the CMS-855A and Processing Information

a. Basic Information (Section 1)

In this section, the provider or supplier indicates the reason for submittal of the application. Unless otherwise stated in this chapter or in another CMS directive, the provider may only check one reason for submittal.

With the exception of (1) the voluntary termination checkbox and (2) the effective date of termination, any blank data/checkboxes in the Basic Information section can be verified through any means chosen by the contractor (e.g., e-mail, telephone, fax).

b. Identifying Information (Section 2)

i. Licenses, Certification, and Accreditation Information

Regarding Licenses, Certifications, and Accreditation Information required in the Identifying Information section of the Form CMS-855A, the extent to which the applicant must complete the licensure, certification, or accreditation information depends upon the provider type involved. Requirements vary by provider type and by location, for instance, some states may require a particular provider or supplier to be “certified” but not “licensed,” or vice versa.

The only licenses that must be submitted with the application are those required by Medicare or the state to function as the provider/supplier type in question. Licenses and permits that are not of a medical nature are not required. If the contractor is aware that a particular state does not require licensure/certification and the “Not Applicable” boxes in the Identifying Information section of the Form CMS-855A are not checked, no further development is needed.

Regarding accreditation under the Identifying Information section of the Form CMS-855A, if the provider checks “Yes,” the contractor shall ensure that the listed accrediting body is one that CMS recognizes in lieu of a State survey or other certification for the provider type in question. If the accrediting body is not recognized by CMS, the contractor shall advise the provider accordingly. (Note, however, that the provider may not intend to use the listed accreditation in lieu of the State survey and merely furnished the accrediting body in response to the question.)

Documents that can only be obtained after state surveys or accreditation need not be included as part of the application, nor must the data be provided in the Identifying Information section of the Form CMS-855A. The provider shall, however, furnish those documents that can be submitted prior to the survey/accreditation. The contractor shall include all submitted licenses, certifications, and accreditations in the enrollment package that is forwarded to the state and/or RO.

ii. Correspondence Address and Telephone Number

The correspondence address in the Correspondence Address and Telephone Number Section of the Form CMS-855A, must be one where the contractor can directly contact the applicant to resolve any issues once the provider is enrolled in the Medicare program. The contractor is not required to verify the correspondence address. 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.

The provider may list any telephone number it wishes as the correspondence phone number in Section the Correspondence Address and Telephone Number Section of the Form CMS-855A. The number need not link to the listed correspondence address. If the provider fails to list a correspondence telephone number and it is required for the application submission, the contractor shall develop for this information – preferably via email or fax. The contractor shall accept a particular phone number if it has no reason to suspect that it does not belong to or is not somehow associated with the provider. The contractor is not required to verify the telephone number.

Unless CMS specifies otherwise, any change in the provider’s phone number or address that the provider did not cause (i.e., area code change, municipality renames the provider’s street) must still be updated via the Form CMS-855A.

iii. E-mail Addresses

Regarding the correspondence e-mail address in Section the Correspondence Address and Telephone Number Section of the Form CMS-855A, the 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.

iv. Other Identifying Information

Other than the TIN and the LBN, the contractor may capture all information in the Correspondence Address and Telephone Number Section of the Form CMS-855A by telephone, e-mail, fax, or a review of the provider or supplier's Web site.

With respect to CHOWs, acquisitions/mergers, and consolidations information captured in the Form CMS-855A, if the old/new owner's current contractor is not listed, the contractor can research this data on its own or obtain it from the provider by any means.

c. Final Adverse Legal Actions/Convictions (Section 3)

Refer to Section 10.6.3 of this chapter for information regarding final adverse actions.

d. Practice Location Information (Section 4)

If a practice location (e.g., hospital unit) has a CMS Certification Number (CCN) that is in any way different from that of the main provider, the contractor shall create a separate enrollment record in PECOS for that location; this does not apply, however, to home health agency (HHA) branches, outpatient physical therapy/outpatient speech pathology (OPT/OSP) extension sites and transplant centers.

Unless CMS specifies otherwise, any change in the provider's phone number or address that the provider did not cause (i.e., area code change, municipality renames the provider's street) must still be updated via the Form CMS-855.

Any provider submitting a Form CMS-855A application must submit the 9-digit ZIP Code for each practice location listed.

For providers/suppliers paid via the Fiscal Intermediary Shared System (FISS), the practice location name entered into the Provider Enrollment, Chain and Ownership System (PECOS) shall be the "doing business as" name (if it is different from the legal business name).

Regarding the contractor's verification of practice locations, the contractor shall verify that the practice locations listed on the application actually exist and is a valid address with the United States Postal Service (USPS). PECOS includes a USPS Address Matching System Application Program Interface (API), which validates address information entered and flags the address if it is determined to be invalid, unknown, undeliverable, vacant, unlikely to deliver mail (No-Stat), a CMRA (i.e., UPS Store, mailboxes, etc.) or a known invalid address false positive. These address types are not permitted in PECOS and are flagged upon entry.

The contractor shall also verify that the reported telephone number is operational and connects to the practice location/business listed on the application. However, the contractor need not contact every location for applicants that are enrolling multiple locations; the contractor can verify each location's telephone number with the contact person listed on the application and note the verification accordingly in the contractor's verification documentation per section 10.6.19(H) of this chapter. (The telephone number must be one where patients and/or customers can reach the applicant to ask questions or register complaints.) The contractor may also match the applicant's telephone number with known, in-service telephone numbers - via, for instance, the Yellow Pages or the Internet - to correlate telephone numbers with addresses. If the applicant uses his/her/its cell phone for their business, the contractor shall verify that this is a telephone connected directly to the business. If the contractor cannot verify the telephone number, it shall request clarifying information from the applicant; the inability to confirm a telephone number may indicate that an onsite visit is necessary. In some instances, a 1-800 number or out-of-state number may be acceptable if the applicant's business location is in another State but his/her/its practice locations are within the contractor's jurisdiction.

If the provider's address and/or telephone number cannot be verified, the contractor shall request clarifying information from the provider. If the provider states that the facility and its phone number are not yet operational, the contractor may continue processing the application. However, it shall indicate in its recommendation letter that the address and telephone number of the facility could not be verified. For purposes of PECOS entry, the contractor can temporarily use the date the certification statement was signed as the effective date.

In section 4A, if the "type of practice location" checkbox is blank, the contractor can confirm the information via e-mail or fax.

i. Do Not Forward (DNF)

Unless instructed otherwise in another CMS directive, the contractor shall follow the DNF initiative instructions in Pub. 100-04, chapter 1, section 80.5. Returned paper checks, remittance notices, or EFT payments shall be flagged if returned from the post office or banking institution, respectively, as this may indicate that the provider's "special payment" address (the Practice Location Information section of the Form CMS-855A) or EFT information has changed. The provider should submit a Form CMS-855A to change this address; if the provider does not have an established enrollment record in the Provider Enrollment, Chain and Ownership System, it must complete an entire Form CMS-855A and Form CMS-588.

In situations where a provider is closing its business and has a termination date (e.g., the provider is closing), the contractor will likely need to make payments for prior services rendered. Since the practice location has been terminated, the contractor may encounter a DNF message. If so, the contractor should request the provider to complete the "special payment" address section of the Form CMS-855A and to sign the certification statement. The contractor, however, shall not collect any other information unless there is a need to do so.

ii. Remittance Notices/Special Payments

For new enrollees, all payments must be made via EFT. The contractor shall thus ensure that the provider has completed and signed the Form CMS-588 and shall verify that the bank account is in compliance with Pub. 100-04, chapter 1, section 30.2.

If an enrolled provider that currently receives paper checks submits a Form CMS-855 change request – no matter what the change involves – the provider must also submit:

- A Form CMS-588 that switches its payment mechanism to EFT. (The change request cannot be processed until the Form CMS-588 is submitted.) All future payments (excluding special payments) must be made via EFT.
- The contractor shall also verify that the bank account is in compliance with Pub. 100-04, chapter 1, section 30.2.

(Once a provider changes its method of payment from paper checks to EFT, it must continue using EFT. A provider cannot switch from EFT to paper checks.)

The “special payment” address may only be one of the following:

- One of the provider’s practice locations
- A P.O. Box
- The provider’s billing agent. The contractor shall request additional information if it has any reason to suspect that the arrangement – at least with respect to any special payments that might be made – may violate the Payment to Agent rules in Pub. 100-04, chapter 1, section 30.2.
- The chain home office address. Per Pub.100-04, chapter 1, section 30.2, a chain organization may have payments to its providers sent to the chain home office. The legal business name of the chain home office must be listed on the Form CMS-588. The TIN on the Form CMS-588 should be that of the provider.
- Correspondence address
- A lockbox. The contractor shall request additional information if it has any reason to suspect that the arrangement, at least with respect to any special payments that might be made, may violate the Payment to Agent rules in Pub. 100-04, chapter 1, section 30.2.

iii. Out-of-State Practice Locations

If a provider is adding a practice location in another State that is within the contractor’s jurisdiction, a separate, initial Form CMS-855A enrollment application is not required if the following 5 conditions are met:

- The location is not part of a separate organization (e.g., a separate corporation, partnership),
- The location does not have a separate tax identification number (TIN) and legal business name (LBN),

- The State in which the new location is being added does not require the location to be surveyed,
- The applicable RO does not require the new location or its owner to sign a separate provider agreement, and
- The location is not a federally qualified health center (FQHCs are required to separately enroll each site)

Consider the following examples:

- The contractor's jurisdiction consists of States X, Y and Z. Jones Skilled Nursing Facility (JSNF), Inc., is enrolled in State X with 3 sites. It wants to add a fourth site in State Y. The new site will be under JSNF, Inc. JSNF will not be establishing a separate corporation, LBN or TIN for the site, and - per the State and RO - a separate survey and provider agreement are not necessary. Since all 5 conditions above are met, JSNF can add the fourth location via a change of information request, rather than an initial application. The change request must include all information relevant to the new location (e.g., licensure, new managing employees). To the extent required, the contractor shall create a separate PECOS enrollment record for the State Y location.
- The contractor's jurisdiction consists of States X, Y and Z. JSNF, Inc., is enrolled in State X with 3 locations. It wants to add a fourth location in State Y, but under a newly created, separate legal entity - JSNF, LP. The fourth location must be enrolled via a separate, initial Form CMS-855A.
- The contractor's jurisdiction consists of States X, Y and Z. Jones Hospice (JH), Inc., is enrolled in State X with 1 location. It wants to add a second location in State Z under JH, Inc. However, it has been determined that a separate survey and certification of the new location are required. A separate, initial Form CMS-855A for the new location is required.

In addition,

- In the Practice Location Information/Where Do You Want Remittance Notices or Special Payments Sent section, if neither box is checked and no address is provided, the contractor can contact the provider by telephone, e-mail, or fax to confirm the provider's intentions. If the provider replies that the "special payments" address is the same as the practice location, no further development is needed. If, however, the provider wants payments to be sent to a different address, the address in Where Do You Want Remittance Notices or Special Payments Sent must be completed via the Form CMS-855A.
- In the Practice Location Information/Base of Operations section, if the "Check here" box is not checked and no address is provided, the contractor can contact the provider by telephone, e-mail or fax to confirm the provider's intentions. If the provider replies that the base of operations address is the same as the practice location, no further development is needed. If the provider indicates that the base of

operations is at a different location, the address in Base of Operations must be completed via the Form CMS-855A.

- In the Practice Location Information/Vehicle Information section, if the vehicle certificates are furnished but the applicable CMS-855A sections are blank, the contractor can verify via telephone, e-mail or fax that said vehicles are the only ones the provider has.

e. Ownership Interest and/or Managing Control Information (Section 5 & 6)

Regarding the Organizational Ownership Interest and/or Managing Control Information section of the Form CMS-855A, Refer to Section 10.6.7(A) – Owning and Managing Organizations and section 10.6.7(C) – Tax Identification Numbers (TINs) of Owning and Managing Organizations and Individuals

Regarding the Individual Ownership Interest and/or Managing Control Information section of the Form CMS-855A, refer to section 10.6.7(B) Owning and Managing Individuals and section 10.6.7(C) – Tax Identification Numbers (TINs) of Owning and Managing Organizations and Individuals

All pages of each submitted Organizational and Individual Ownership Interest and/or Managing Control Information section of the CMS-855A must be present when submitted. If these sections are incomplete, the contractor shall develop for all missing pages.

f. Chain Home Office Information (Section 7)

All providers that are currently part of a chain organization or are joining a chain organization must complete the Chain Home Office Information section of the Form CMS-855A with information about the chain home office. Under 42 CFR §421.404, a “home office” means the entity that provides centralized management and administrative services to the providers or suppliers under common ownership and common control, such as centralized accounting, purchasing, personnel services, management direction and control, and other similar services. Other definitions relevant to chain organizations (and which are in §421.404) include:

- Chain provider - A group of two or more providers under common ownership or control.
- Common control - Exists when an individual, a group of individuals, or an organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of the group of suppliers or eligible providers.
- Common ownership – Exists when an individual, a group of individuals, or an organization possesses significant equity in the group of suppliers or eligible providers.

The contractor shall not delay its processing of the provider’s application while awaiting the issuance of a chain home office number (i.e., a determination as to whether a set of entities qualifies as a chain organization). Such an issuance/determination is not required for a recommendation for approval.

A chain home office is required to be listed in the Organizational Ownership Interest and/or Managing Control Information section of the Form CMS-855A.

If a chain organization listed in the Chain Home Office Information section of the Form CMS-855A also serves as the provider's billing agent, the chain must be listed in the Billing Agency section of the Form CMS-855A as well.

If all of the Chain Home Office Information section is blank (including the check box in this section), no additional development is necessary.

If the provider indicates that it is part of a chain but the checkboxes in the Chain Home Office Information section are blank, the contractor can verify the type of transaction involved via e-mail or fax.

In the Chain Home Office Information/Chain Home Office Administrator section, if the person is also listed with complete information in Individual Ownership Interest and/or Managing Control Information section (e.g., the individual's Social Security Number (SSN) is listed in the Individual Ownership Interest and/or Managing Control Information section), only the individual's first and last name need be listed in the Chain Home Office Information section.

In the Chain Home Office Information/Chain Home Office Information section, if the entity is also listed with complete information in the Organizational Ownership Interest and/or Managing Control Information section, the company's legal business name is the only data that must be listed in the Chain Home Office Information section. (If blank, the cost report date, the home office's contractor, and the chain number can be developed by phone, e-mail, or fax.)

If blank, data in the Chain Home Office Information section (Type of Action this Provider is Reporting, Type of Business Structure of the Chain Home Office or the Provider's Affiliation to the Chain Home Office), can be collected by telephone, e-mail or fax.

In addition, the contractor shall ensure that:

- The chain home office is identified in the Organizational Ownership and/or Managing Control Section and that final adverse action data is furnished in the Organizational Ownership Interest and/or Managing Control Information section. (For purposes of provider enrollment, a chain home office automatically qualifies as an owning/managing organization.) Note that a National Provider Identifier (NPI) is typically not required for a chain home office.
- The chain home office administrator is identified in the Individual Ownership Interest and/or Managing Control Information section and that final adverse action data for the administrator is also furnished in this section. (For purposes of provider enrollment, a chain home office administrator is automatically deemed to have managing control over the provider.)

For more information on chain organizations, refer to:

- Pub. 100-04, chapter 1, sections 20.3 through 20.3.6
- 42 CFR §421.404

- CMS change request 5720

g. Billing Agency Information (Section 8)

Regarding the Billing Agency Information section of the Form CMS-855A, refer to Section 10.6.8 of this chapter.

If the chain organization listed in the Chain Home Office Information section of the Form CMS-855A also serves as the provider's billing agent, the chain must be listed in the Billing Agency Information section as well.

If the telephone number is blank, the number can be verified with the provider by telephone, e-mail or fax.

If all of the Billing Agency Information section is blank (including the check box), no additional development is necessary.

h. Special Requirements for Home Health Agencies (Section 12)

Regarding the Special Requirements for Home Health Agencies section of the Form CMS-855A, refer to 10.2.1(F) "Home Health Agencies (HHAs)"

If it is obvious that the entity is not enrolling as a home health agency (HHA), the checkbox above this section can be left blank.

If the entity is an HHA:

- If the Special Requirements for Home Health Agencies/Type of Home Health Agency or Financial Documentation sections is/are blank, the data can be verified by telephone, e-mail, or fax.
- If the telephone number in the Special Requirements for Home Health Agencies section is blank, the number can be verified with the provider by telephone, e-mail or fax.

i. Contact Persons (Section 13)

Regarding the Contact Person section of the Form CMS-855A, refer to section 10.6.9 of this chapter.

- If this section is completely blank, the contractor need not develop for this information and can simply contact an authorized or delegated official.
- If neither box is checked but the contact person information is incomplete (e.g., no telephone number listed), the contractor may either (1) develop for this information by telephone, e-mail or fax, or (2) contact an authorized or delegated official.
- Currently there is no option on the CMS-855A form to delete a contact person. Therefore, contractors shall accept end dates of a contact person via phone, email, fax or mail from the individual provider, the Authorized or Delegation official, or a current contact person on file. Contractors shall document in the comment section in PECOS who requested the termination, how it was requested (email, phone or fax) and when it

was requested. The addition of contact persons must still be reported via the appropriate CMS-855A form.

j. Penalties for Falsifying Information (Section 14)

Please refer to the Penalties for Falsifying Information section of the Form CMS-855A for an explanation of penalties that apply to providers and suppliers for deliberately furnishing false information in this application to gain or maintain enrollment in the Medicare program.

k. Certification Statement (Section 15)

Unless otherwise specified, the instructions in this section apply to: (1) signatures on the paper Form CMS-855A, (2) signatures on the certification statement for Internet-based Provider Enrollment, Chain and Ownership System (PECOS) applications, and (3) electronic signatures.

Valid signatures include handwritten (wet) signatures in ink and digital/electronic signatures (digital or electronic signatures such as those created by digital signature options, created in software, such as Adobe) shall be accepted. Contractors shall contact their PEOG BFL for questions regarding electronic signatures.

All signatures (handwritten or digital) are valid and appropriate in regards to (1) signatures on the paper Form CMS-855A (2) uploaded signatures on the certification statement for Internet-based Provider Enrollment, Chain and Ownership System (PECOS) applications.

i. Paper Submissions

A signed certification statement shall accompany the paper CMS-855A application. If the provider submits an invalid certification statement or fails to submit a certification statement, the contractor shall still proceed with processing the application. An appropriate certification statement shall be solicited as part of the development process – preferably via email or fax. This includes certification statements that are: (a) unsigned; (b) undated; (c) was signed (as reflected by the date of signature) more than 120 days prior to the date on which the contractor received the application); (d) missing certification statements, or (e) stamped. The contractor shall send one development request to include a list of all of the missing required data/documentation, including the certification statement. The contractor may reject the provider's application if the provider fails to furnish the missing information on the enrollment application - including all necessary documentation - within 30 calendar days from the date the contractor requested the missing information or documentation. Unless stated otherwise in this chapter or in another CMS directive:

- The contractor shall begin processing the application upon receipt and shall develop for missing certification statements and all other missing information, including application fee, upon review.
- The certification statement may be returned via scanned email or fax.

- Signature dates cannot be prior to 120 days of the receipt date of the application.
- For paper applications that require development, it is only necessary that the dated signature of at least one of the provider's authorized or delegated officials be on the certification statement that must be sent in within 30 days; obtaining the signatures of the other authorized and delegated officials is not required, unless the contractor is requesting signatures of the other authorized and delegated officials.
- For paper changes of information applications (as the term "changes of information" is defined in section 10.4(J) of this chapter), if the certification statement is signed by an individual who is not on file with the contractor as being an authorized or delegated official of the provider, the contractor may accept the certification statement but shall develop for information on the person in question in accordance with section 10.3.1(A)(1)(k).
- The contractor is not required to compare the signature thereon with the same provider, authorized or delegated official's signature on file to ensure that it is the same person. The contractor shall not request the submission of a driver's license or passport to verify a signature.

ii. Certification Statement: Internet-based PECOS Submissions

If the provider submits its application online and chooses to submit its certification statement via paper rather than through e-signature, it shall do so via PECOS upload functionality. The provider shall not mail in its paper certification statement as it will not be accepted. Unless stated otherwise in this chapter or in another CMS directive:

- The contractor shall begin processing the application upon receipt and shall develop for missing certification statements and all other missing information, including application fee, upon review.
- Signature dates cannot be prior to 120 days of the receipt date of the application.
- If the provider submits an invalid certification statement, the contractor shall treat this as missing information and develop for a correct certification statement – preferably via email or fax. This includes certification statements that are: (a) unsigned; (b) undated; (c) was signed (as reflected by the date of signature) more than 120 days prior to the date on which the contractor received the application); (d) missing certification statements, or (e) stamped. The contractor shall send one development request to include a list of all of the missing required data/documentation, including the certification statement. The contractor may reject the provider's application if the provider fails to furnish the missing 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 Internet-based PECOS applications that require development, it is only necessary that the dated signature of at least one of the provider's authorized or delegated officials be on the certification statement that must be sent in within 30 days; obtaining the signatures of the other authorized and delegated officials is not required, unless the contractor is requesting signatures of the other authorized and delegated officials.
- For Internet-based PECOS changes of information applications (as the term "changes of information" is defined in section 10.4(J) of this chapter), if the certification statement is signed by an individual who is not on file with the contractor as being an authorized or delegated official of the provider, the contractor may accept the certification statement but shall develop for information on the person in question in accordance with section 10.3.1(A)(1)(k).
- The contractor is not required to compare the signature thereon with the same provider, authorized or delegated official's signature on file to ensure that it is the same person. The contractor shall not request the submission of a driver's license or passport to verify a signature.

iii. Certification Statement Development

If the provider submits an invalid certification statement (e.g., unsigned; undated; or stamped signature; signed more than 120 days of the receipt date, incorrect individual signed it; not all authorized officials signed it) or neglects to send a certification statement, the contractor shall treat this as missing information and develop for a correct certification statement using the procedures outlined in this chapter. The contractor shall send a development letter to the provider – preferably via email or fax.

Any development requests that require the submission of a newly signed certification statement may be submitted for paper applications via scanned email, fax, or mail; and for web applications by upload, fax, email or e-signature. Only the actual signature page is required; the additional page containing the certification terms need not be submitted. This also applies to the provider's initial submission of a certification statement; such instances require the submission of only the signature page and not the certification terms.

In addition, the Authorized Official's telephone number can be left blank. No further development is needed.

iv. Authorized Officials

An authorized official must be a 5 percent direct owner, chairman of the board, etc., of the enrolling provider with the authority to bind the provider or supplier, both legally and financially, to the requirements set forth in 42 CFR §424.510. This person must also have an ownership or control interest in the provider or supplier, such as, the general partner, chairman of the board, chief financial officer, chief executive officer, president, or hold a position of similar status and authority within the provider or supplier organization. One cannot use his/her status as the chief executive officer, chief financial

officer, etc., of the provider's parent company, management company, or chain home office as a basis for his/her role as the provider's authorized official.

An authorized official is an appointed official (for example, chief executive officer, chief financial officer, general partner, chairman of the board, or direct owner) to whom the organization has granted the legal authority to enroll it in the Medicare program, to make changes or updates to the organization's status in the Medicare program, and to commit the organization to fully abide by the statutes, regulations, and program instructions of the Medicare program. An AO is not restricted to the examples of the titles outlined above but is applicable to an equivalent that is an appointed official to whom the organization has granted the legal authority to act on behalf of the organization. These additional titles could include, but are not limited to, executive directors, administrator, president, vice president. Contractors shall consider the individual's title as well as the authority granted by the organization when determining whether an individual qualifies as an AO when processing enrollment applications. If the contractor is unsure of an AO's qualifications or authority, they shall contact their Provider Enrollment Oversight Group (PEOG) Business Function Lead (BFL) for further clarification. The contractor shall obtain PEOG BFL approval if the only role of the listed AO is "Contracted Managing Employee" despite title and other qualifications, the BFL will confirm authority.

If an authorized official is listed as a "Contracted Managing Employee" in the Individual Ownership and/or Managing Control section of the Form CMS-855A and does not qualify as an authorized official under some other category in the Individual Ownership and/or Managing Control section, he/she cannot be an authorized official. The contractor shall notify the provider accordingly. If the person is not listed as a "Contracted Managing Employee" in the Individual Ownership Interest and/or Managing Control Information section and the contractor has no reason to suspect that the person does not qualify as an authorized official, no further investigation is required. Should the contractor have doubts that the individual qualifies as an authorized official, it shall contact the official or the applicant's contact person to obtain more information about the official's job title and/or authority to bind. If the contractor remains unconvinced that the individual qualifies as an authorized official, it shall notify the provider that the person cannot be an authorized official. If that person is the only authorized official listed and the provider refuses to use a different authorized official, the contractor shall deny the application.

v. Deletion of Authorized Official

If an authorized official is being deleted, the contractor need not obtain (1) that official's signature, or (2) documentation verifying that the person is no longer an authorized official.

vi. Change in Authorized Officials

A change in authorized officials does not impact the authority of existing delegated officials to report changes and/or updates to the provider's enrollment data or to sign revalidation applications.

vii. Authorized Official Not on File

If the provider submits a change of information (e.g., change of address) and the authorized official signing the form is not on file, the contractor shall ensure that: (1) the person meets the definition of an authorized official, and (2) the Individual Ownership Interest and/or Managing Control Information section of the Form CMS-855 is completed for that person. The signature of an existing authorized official is not needed in order to add a new authorized official. Note that the original change request and the addition of the new official shall be treated as a single change request (i.e., one change request encompassing two different actions) for purpose of enrollment processing and reporting.

viii. Effective Date

The effective date in the Provider Enrollment, Chain and Ownership System for the Certification Statement section for Authorized Officials of the Form CMS-855 should be the date of signature.

ix. Social Security Number

To be an authorized official, the person must have and must submit his/her social security number (SSN). An Individual Taxpayer Identification Number (ITIN) cannot be used in lieu of an SSN in this regard.

x. Identifying the Provider

As stated earlier, an authorized official must be an authorized official of the provider, not of an owning organization, parent company, chain home office, or management company. Identifying the provider is not - for purposes of determining an authorized official's qualifications - determined solely by the provider's tax identification number (TIN). Rather, the organizational structure is the central factor. For instance, suppose that a chain drug store, Company X, wants to enroll 100 of its pharmacies with the contractor. Each pharmacy has a separate TIN and must therefore enroll separately. Yet all of the pharmacies are part of a single corporate entity – Company X. In other words, there are not 100 separate corporations in our scenario, but merely one corporation whose individual locations have different TINs. Here, an authorized official for Pharmacy #76, can be someone at X's headquarters (assuming that the definition of authorized official is otherwise met), even though this main office might be operating under a TIN that is different from that of #76. This is because headquarters and Pharmacy #76 are part of the same organization/corporation. Conversely, if #76 was a corporation that was separate and distinct from Company X, only individuals that were part of #76 could be authorized officials.

xi. Signatory Requirements

Valid Signatures - For non-electronic application submissions, the following authorized and delegated officials' signatures can be accepted are discussed in Section 10.3.1(A)(1)(k) of this chapter.

If the contractor should receive a digital signature that differs from the example above, the contractor shall reach out to their Provider Enrollment & Oversight Group Business Function Lead (PEOG BFL).

For Form CMS-855A initial applications, the certification statement must be signed and dated by an authorized official of the provider. (See section 10.1.1 of this chapter for a definition of “authorized official.”) The provider can have an unlimited number of authorized officials, so long as each meets the definition of an authorized official. The Individual Ownership and/or Managing Control section of the Form CMS-855 or CMS-20134 must be completed for each authorized official.

For Form CMS-855A applications submitted to change, update and/or revalidate the provider or supplier’s Medicare enrollment data, the certification statement may be signed and dated by the authorized or delegated official of the provider or supplier. This applies to: (1) signatures on the paper Form CMS-855, (2) signatures on the certification statement for Internet-based Provider Enrollment, and electronic signatures.

Any development requests that require the submission of a newly signed certification statement may be submitted for paper applications via scanned email, fax, or mail; and for web applications by upload, fax, email or e-signature. Only the actual signature page is required; the additional page containing the certification terms need not be submitted. This also applies to the provider’s initial submission of a certification statement; such instances require the submission of only the signature page and not the certification terms.

I. Delegated Officials (Section 16)

A delegated official is an individual to whom an authorized official listed in the Certification Statement section of the Form CMS-855A delegates the authority to report changes and updates to the provider’s enrollment record or to sign revalidation applications. The delegated official’s signature binds the organization both legally and financially, as if the signature was that of the authorized official. Before the delegation of authority is established, the only acceptable signature on the enrollment application to report updates or changes to the enrollment information is that of the authorized official currently on file with Medicare. The delegated official must be an individual with an “ownership or control interest” in (as that term is defined in §1124(a)(3) of the Social Security Act), or be a W-2 managing employee of the provider.

Section 1124(a)(3) defines an individual with an ownership or control interest as:

- A five percent direct or indirect owner of the provider,
- An officer or director of the provider (if the provider is a corporation), or
- Someone with a partnership interest in the provider, if the provider is a partnership

The delegated official must be a delegated official of the provider, not of an owning organization, parent company, chain home office, or management company. One cannot use his/her status as a W-2 managing employee of the provider’s parent company, management company, or chain home office as a basis for his/her role as the provider’s delegated official.

The Ownership Interest and Managing Control Information for Individuals of Form CMS-855A must be completed for all delegated officials.

A delegated official has no authority to sign an initial application. However, the delegated official may (i) sign a revalidation application and (ii) sign off on changes/updates submitted in response to a contractor's request to clarify or submit information needed to continue processing the provider's initial application.

Further Delegation - Delegated officials may not delegate their authority to any other individual. Only an authorized official may delegate the authority to make changes and/or updates to the provider's Medicare data or to sign revalidation applications.

Regarding managing employees, for purposes of the Delegated Officials information captured in the Delegated Official section only, the term "managing employee" means any individual, including a general manager, business manager, or administrator, who exercises operational or managerial control over the provider, or who conducts the day-to-day operations of the provider. However, this does not include persons who, either under contract or through some other arrangement, manage the day-to-day operations of the provider but who are not actual W-2 employees. For instance, suppose the provider hires Joe Smith as an independent contractor to run its day-to-day-operations. Under the definition of "managing employee" in the Ownership Interest and Managing Control Information for Individuals section of the Form CMS-855A, Smith would have to be listed in that section. Yet under the Delegated Officials section definition (as described above), Smith cannot be a delegated official because he is not an actual W-2 employee of the provider. Independent contractors are not considered "managing employees" under the Delegated Officials section of the Form CMS-855A.

i. W-2 Form

Unless the contractor requests it to do so, the provider is not required to submit a copy of the owning/managing individual's W-2 to verify an employment relationship.

ii. Number of Delegated Officials

The provider can have as many delegated officials as it chooses. Conversely, the provider is not required to have any delegated officials. Should no delegated officials be listed, the authorized official(s) remains the only individual(s) who can report changes and/or updates to the provider's enrollment data.

iii. Effective Date

The effective date in PECOS for the Delegated Official section of the Form CMS-855A should be the date of signature.

iv. Social Security Number

To be a delegated official, the person must have and must submit his/her social security number. An Individual Taxpayer Identification Number (ITIN) cannot be used in lieu of an SSN in this regard.

v. Deletion of a Delegated Official

If a delegated official is being deleted, documentation verifying that the person no longer is or qualifies as a delegated official is not required. Also, the signature of the deleted official is not needed.

vi. Delegated Official Not on File

If the provider submits a change of information (e.g., change of address) and the delegated official signing the form is not on file, the contractor shall ensure that (1) the person meets the definition of a delegated official, (2) the Individual Ownership and/or Managing Control section of the Form CMS-855A is completed for that person, and (3) an authorized official signs off on the addition of the delegated official. (NOTE: The original change request and the addition of the new official shall be treated as a single change request (i.e., one change request encompassing two different actions) for purpose of enrollment processing and reporting.)

Signature on Paper Application - If the provider submits a paper Form CMS-855A change request, the contractor may accept the signature of a delegated official in the Certification Statement or Delegated Official sections of the Form CMS-855A.

In addition, the Delegated Official's telephone number can be left blank. No further development is needed.

m. Supporting Documents

Refer to the Supporting Documents section of the CMS Form-855A for information concerning supporting documents.

2. Additional Processing Information and Alternatives for Form CMS-855A

a. Unsolicited Additional Information

Regarding unsolicited additional information, if the provider submits missing/clarifying data or documentation on its own volition (i.e., without being contacted by the contractor), the contractor shall include this additional data/documentation in its overall application review. Any new or changed information that a provider submits prior to the date the contractor finishes processing a previously submitted change request is no longer considered to be an update to that change request. Rather, it is considered to be and shall be processed as a separate change request. The contractor may process both changes simultaneously, but the change that was submitted first shall be processed to completion prior to the second one being processed to completion.

b. Non-Enrollment Functions

In some instances, the contractor cannot forward an application to the State until it performs certain non-enrollment functions pertaining to the application (e.g., the reimbursement unit needs to examine patient listing data). The contractor may change the provider's status in the Provider Enrollment, Chain and Ownership System (PECOS) to "approval recommended" prior to the conclusion of the non-enrollment activity if: (1) all required enrollment actions have been completed, and (2) the non-enrollment action is the only remaining activity to be performed.

c. Multiple Providers under a Single Tax Identification Number (TIN)

Multiple providers may have the same TIN. However, each provider must submit a separate Form CMS-855A application and the contractor must create a separate enrollment record for each.

d. Future Effective Dates

If the contractor cannot enter an effective date into PECOS because the provider, practice location, etc., is not yet established, the contractor may use the authorized official's date of signature as the temporary effective date. Once the actual effective date is established (e.g., the tie-in notice is received), the contractor shall change the effective date in PECOS.

e. Provider-Based Entities

The contractor shall adhere to the following regarding the enrollment of provider-based entities:

- **Certified Provider or Certified Supplier Initially Enrolling** – Suppose an HHA or other certified provider or certified supplier wishes to enroll and become provider-based to a hospital. The provider/supplier must enroll with the contractor as a separate entity. It cannot be listed as a practice location on the hospital's Form CMS-855A.
- **Certified Provider or Certified Supplier Changing its Provider-Based Status** – If a certified provider or certified supplier is changing its status from provider-based to freestanding or vice versa, it need not submit any updates to its Form CMS-855A enrollment.
- **Group Practice Initially Enrolling** – If a group practice is enrolling in Medicare and will become provider-based to a hospital, the group generally must enroll via the Form CMS-855B if it wants to bill for practitioner services. The group would also need to be listed or added as a practice location on the hospital's Form CMS-855A.
- **Group Practice Changing from Provider-Based to Freestanding** – In this situation, the hospital should submit a Form CMS-855A change request that deletes the clinic as a practice location. The group may also need to change the type of clinic it is enrolled as; this may require a new Form CMS-855B.
- **Group Practice Changing from Freestanding to Provider-Based** – Here, the hospital must submit a Form CMS-855A change request adding the group as a practice location. The group may also need to change the type of clinic it is enrolled as; this may require a new Form CMS-855B.
- Unless the CMS regional office (RO) dictates otherwise, the contractor shall not delay the processing of any practice location addition applications pending receipt of provider-based attestations or RO approval of provider-based status.

f. Information Disclosed Elsewhere

Applicable to all sections of the Form-855A, if a data element on the provider's Form CMS-855A application is missing but the information is disclosed (1) elsewhere on the

application or (2) in the supporting documentation submitted with the application, the contractor need not obtain the missing data via an updated Form CMS-855A page and a newly-signed certification statement; no further development – not even by telephone – is required. The following information, however, must be furnished in the appropriate section(s) of the Form CMS-855A, even if the data is identified elsewhere on the form or in the supporting documentation:

- All organizational and individual ownership and managing control information of the Form CMS-855A
- Any final adverse action data requested in the Final Adverse Legal Actions/Convictions section and the final adverse legal action history for any organization or individual listed in the Ownership Interest and/or Managing Control Information sections of the Form CMS-855A
- All legal business names (LBNs) (e.g., provider, chain home office)
- Note: If an application is submitted with a valid NPI and CCN combination, but the LBN field is blank, an incomplete or inaccurate LBN is submitted, or the applicant includes a DBA name in the Practice Location Information section of the Form CMS-855A and the contractor is able to confirm the correct LBN based on the NPI and CCN combination provided, the contractor is not required to develop.
- All tax identification numbers (TINs) (e.g., provider, owning organization)
- NPI-legacy number combinations in the Practice Location Information section of the Form CMS-855A
- Note: MACs may use the shared systems, PECOS or their provider files as a resource to determine the PTAN or NPI before developing to the provider.
- Provider type
- The following data in the Change of Ownership (CHOW), Acquisitions/Mergers or Consolidations sections of the CMS-855A:
 - “Doing business as” name
 - Effective dates of sale/transfer/consolidation
 - Checkbox in the Identifying Information (CHOW Information) section indicating whether buyer will accept assets/liabilities
 - Names of units with separate legacy numbers/NPIs;
 - All NPIs and legacy numbers (MACs may use the shared systems, PECOS or their provider files as a resource to determine the CCN or NPI before developing to the provider).

If the supporting documentation currently exists in the provider’s file, the provider or supplier is not required to submit that documentation again during the enrollment process. The MAC shall utilize the existing documentation for verification. Documentation

submitted with a previously submitted enrollment application, or documentation currently uploaded in PECOS, qualifies as a processing alternative, unless stated otherwise in this chapter or any CMS directive. Also, per section 10.6.19(H) of this chapter, the contractor shall document in the provider file that the missing information was found elsewhere in the enrollment package. This excludes information that must be verified at the current point in time (i.e. a license without a primary source verification method). Additionally, contractors shall not utilize information submitted along with opt-out applications for enrollment application processing or vice-versa.

g. Licenses

In situations where the provider is required to submit a copy of a particular professional or business license, certification, or registration but fails to do so, the contractor need not obtain such documentation from the provider if the contractor can verify the information independently. This may be done by: (1) reviewing and printing confirmation pages from the applicable state web site, (2) requesting and receiving from the appropriate state body written confirmation of the provider's status therewith, and (3) using any other third-party verification source. Similarly, if the provider submits a copy of the applicable license, certification, or registration but fails to complete the appropriate section of the form, the section need not be completed if the data in question can be verified on the license/certification itself or via any of the three mechanisms above.

- The above-referenced written confirmation from a state body of the provider's status can be in the form of a letter, fax, or e-mail, but it must be in writing. Documentation of a verbal conversation between the contractor and the body in question does not qualify as appropriate confirmation.
- This exception only applies to those documents that traditionally fall within the category of licenses, registrations, or certifications. It does not apply to items such as adverse action documentation, bills of sale, etc. Furthermore, the exception is moot in cases where: (1) a particular license/certification is not required by the state, or (2) the license/certification has not been obtained because a state survey has not yet been performed.

h. City, State, and ZIP Code

Applicable to all sections of the Form-855, if an address (e.g., correspondence address, practice location) lacks a city, state or zip + four, the contractor can verify the missing data in any manner it chooses. In addition, the contractor can obtain the "zip + four" from either the U.S. Postal Service or the Delivery Point Validation in PECOS.

B. CMS-855B –Medicare Enrollment Application for Clinics, Group Practices, and Certain Other Suppliers

This application should be completed by supplier organizations (e.g., ambulance companies) that will bill Medicare for Part B services furnished to Medicare beneficiaries. It is not used to enroll individuals.

1. Sections of the CMS-855B and Processing Information

a. Basic Information (Section 1)

In this section, the provider or supplier indicates the reason for submittal of the application. Unless otherwise stated in this chapter or in another CMS directive, the provider may only check one reason for submittal.

For example, suppose a supplier is changing its tax identification number via the Form CMS-855B. The supplier must submit two applications: (1) an initial Form CMS-855B as a new supplier, and (2) a Form CMS-855B voluntary termination. Both transactions cannot be reported on the same application.

With the exception of: (1) the voluntary termination checkbox and (2) the effective date of termination data in the Basic Information section of the Form CMS-855B, any blank data/checkboxes in this section can be verified through any means chosen by the contractor (e.g., e-mail, telephone, fax).

b. Identifying Information (Section 2)

i. Licenses, Certifications and Accreditation Information

Regarding licensure information in the Identifying Information Section of the Form CMS-855B, the extent to which the applicant must complete the licensure, certification, or accreditation information depends upon the provider type involved. Requirements vary by provider type and by location, for instance, some states may require a particular provider or supplier to be “certified” but not “licensed,” or vice versa.

The only licenses that must be submitted with the application are those required by Medicare or the state to function as the provider/supplier type in question. Licenses and permits that are not of a medical nature are not required. In addition, there may be instances where the supplier is not required to be licensed at all in a particular state; the contractor shall still ensure, however, that the supplier meets all applicable state and Medicare requirements.

If the contractor is aware that a particular state does not require licensure/certification and the “Not Applicable” boxes are not checked in the Identifying Information Section of the Form CMS-855B, no further development is needed.

In situations where the supplier is required to submit a copy of a particular professional or business license, certification or registration but fails to do so, the contractor need not obtain such documentation from the provider if the contractor can verify the information independently. This may be done by: (1) reviewing and printing confirming pages from the applicable state or professional web site, (2) requesting and receiving from the appropriate state, professional, or educational body written confirmation of the supplier’s status therewith, or (3) utilizing another third-party verification source. Similarly, if the provider submits a copy of the applicable license, certification, or registration but fails to complete the applicable section of the form, the section need not be completed if the data in question can be verified on the license/certification itself or via any of the three mechanisms described above. The above-referenced written confirmation of the supplier’s status can be in the form of a letter, fax, or e-mail, but it must be in writing. Documentation of a verbal conversation between the contractor and the body in question does not qualify as appropriate confirmation. This exception only applies to those documents that traditionally fall within the category of licenses, registrations, or certifications. It does not apply to items such as adverse action documentation, paramedic intercept services documents, etc. Furthermore, the exception

is moot in cases where: (1) a particular license/certification is not required by the state, or (2) the license/certification has not been obtained because a state survey has not yet been performed (i.e., for certified suppliers).

The contractor shall verify that the supplier is licensed and/or certified to furnish services in:

- The state where the supplier is enrolling.
- Any other state within the contractor's jurisdiction in which the supplier (per the "Practice Location Information" section of the Form CMS-855B) will maintain a practice location

Regarding revoked/suspended licenses: If the applicant had a previously revoked or suspended license reinstated, the applicant must submit a copy of the reinstatement notice with the application.

Regarding license expiration/revocation dates for non-certified suppliers: For expired licenses, the contractor shall enter into PECOS the day after the expiration as the expiration date. For revoked and suspended licenses, the contractor shall enter into PECOS the revocation date (not the day after) as the expiration date.

A. Clinical Laboratory Improvement Act (CLIA) and Drug Enforcement Agency (DEA)

CLIA and DEA certificates are not required. If the applicable CLIA and DEA certificates are not furnished or the applicable Form CMS-855 sections are blank, no further development is needed.

See section 10.6.19(S)(1)(a) of this chapter for special instructions related to periodic license reviews and certain program integrity matters.

ii. Supplier Identification Information

Regarding Supplier Identification Information – Business Information, the contractor may capture all information in the Identifying Information Section (with the exception of the TIN and LBN) by telephone, fax, e-mail, or a review of the provider or supplier's Web site.

iii. Physical Therapy/ Occupational Therapy Groups

Any supplier that indicates it is a PT/OT group must complete the questionnaire in the Identifying Information Section for PT/OT groups. In doing so:

- If the group indicates that it renders services in patients' homes, the contractor shall verify that the group has an established private practice where it can be contacted directly and where it maintains patients' records.
- If the group answers "yes" to question 2, 3, 4, or 5, the contractor shall request a copy of the lease agreement giving the group exclusive use of the facilities for PT/OT services only if it has reason to question the accuracy of the group's

response. If the contractor makes this request and the provider cannot furnish a copy of the lease, the contractor shall deny the application.

iv. State Surveys

Documents that can only be obtained after state surveys or accreditation need not be included as part of the application. (This typically occurs with ASCs and portable x-ray suppliers.) The supplier must, however, furnish those documents that can be submitted prior to the survey/accreditation.

The contractor shall include any licenses, certifications, and accreditations submitted by suppliers in the enrollment package that is forwarded to the state and/or RO.

Once the contractor receives the approval letter or tie-in notice from the RO for a supplier, the contractor is encouraged, but not required, to contact the RO, state agency, or supplier for the applicable licensing and/or certification data and to enter it into PECOS.

v. Notarization

If the applicant submits a license that is not notarized or "certified true," the contractor shall verify the license with the appropriate state agency. (A notarized copy of an original document has a stamp that says "official seal," along with the name of the notary public, the state, the county, and the date the notary's commission expires. A certified "true copy" of an original document has a raised seal that identifies the state and county in which it originated or is stored.)

vi. Correspondence Address and Telephone Number

The correspondence address in the Correspondence Address and Telephone Number Section of the Form CMS-855B, must be one where the contractor can directly contact the applicant to resolve any issues once the provider is enrolled in the Medicare program. The contractor is not required to verify the correspondence address. 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.

Regarding the telephone number in the Identifying Information Section of the Form CMS-855B, the provider may list any telephone number it wishes as the correspondence phone number. The number need not link to the listed correspondence address. If the provider fails to list a correspondence telephone number and it is required for the application submission, the contractor shall develop for this information – preferably via email or fax. The contractor shall accept a particular phone number if it has no reason to suspect that it does not belong to or is not somehow associated with the provider. The contractor is not required to verify the telephone number.

vii. 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.

Regarding unavoidable phone number or address changes, unless CMS specifies otherwise, any change in the provider's phone number or address that the provider did not cause (i.e., area code change, municipality renames the provider's street) must still be updated via the Form CMS-855B.

c. Final Adverse Legal Actions/Convictions (Section 3)

Refer to Section 10.6.6 of this chapter for information regarding final adverse actions.

d. Practice Location Information (Section 4)

Unless CMS specifies otherwise, any change in the provider's phone number or address that the provider did not cause (i.e., area code change, municipality renames the provider's street) must still be updated via the Form CMS-855B.

Any provider submitting a Form CMS-855B application must submit the 9-digit ZIP Code for each practice location listed.

For suppliers paid via the Multi-Carrier System (MCS), the practice location name entered into PECOS shall be the legal business name.

Regarding the contractor's verification of practice locations, the contractor shall verify that the practice locations listed on the application actually exist and is a valid address with the United States Postal Service (USPS). PECOS includes a USPS Address Matching System Application Program Interface (API), which validates address information entered and flags the address if it is determined to be invalid, unknown, undeliverable, vacant, unlikely to deliver mail (No-Stat), a CMRA (i.e., UPS Store, mailboxes, etc.) or a known invalid address false positive. These address types are not permitted in PECOS and are flagged upon entry.

The contractor shall also verify that the reported telephone number is operational and connects to the practice location/business listed on the application. However, the contractor need not contact every location for applicants that are enrolling multiple locations; the contractor can verify each location's telephone number with the contact person listed on the application and note the verification accordingly in the contractor's verification documentation per section 10.6.19(H) of this chapter. (The telephone number must be one where patients and/or customers can reach the applicant to ask questions or register complaints.) The contractor may also match the applicant's telephone number with known, in-service telephone numbers - via, for instance, the Yellow Pages or the Internet - to correlate telephone numbers with addresses. If the applicant uses his/her/its cell phone for their business, the contractor shall verify that this is a telephone connected directly to the business. If the contractor cannot verify the telephone number, it shall request clarifying information from the applicant; the inability to confirm a telephone number may indicate that an onsite visit is necessary. In some instances, a 1-800 number or out-of-state number may be acceptable if the applicant's business location is in another State but his/her/its practice locations are within the contractor's jurisdiction.

For certified suppliers (i.e.: Ambulatory Surgical Centers or Portable X-Ray Suppliers), if the supplier's address and/or telephone number cannot be verified, the contractor shall request clarifying information from the supplier. If the supplier states that the facility and its phone number are not yet operational, the contractor may continue processing the

application. However, it shall indicate in its recommendation letter that the address and telephone number of the facility could not be verified. For purposes of PECOS entry, the contractor can temporarily use the date the certification statement was signed as the effective date.

In section 4A, if the “type of practice location” checkbox is blank, the contractor can confirm the information via e-mail or fax.

In section 4B, if neither box is checked and no address is provided, the contractor can contact the supplier by telephone, email, or fax to confirm the supplier’s intentions. If the “special payments” address is indeed the same as the practice location, no further development is needed. If, however, the supplier wants payments to be sent to a different address, the address in 4B must be completed via the Form CMS-855B.

If the supplier: (1) is adding a practice location and (2) is normally required to complete a questionnaire in the Form CMS-855B specific to its supplier type (i.e.: physical or occupational therapist groups), the entity must submit an updated questionnaire to incorporate services rendered at the new location.

In section 4E, if the “Check here” box is not checked and no address is provided, the contractor can contact the supplier by telephone, email or fax to confirm the supplier’s intentions. If the base of operations address is the same as the practice location, no further development is needed. If the supplier indicates that the base of operations is at a different location, the address in 4E must be completed via the Form CMS-855.

In section 4F, if the vehicle certificates are furnished but the applicable Form CMS-855 sections are blank, the contractor can verify via telephone, email or fax that said vehicles are the only ones the supplier has.

i. Do Not Forward (DNF)

Unless instructed otherwise in another CMS directive, the contractor shall follow the DNF initiative instructions in Pub. 100-04, chapter 1, section 80.5. Returned paper checks, remittance notices, or EFT payments shall be flagged if returned from the post office or banking institution, respectively, as this may indicate that the provider’s “special payment” address (the Practice Location Information section of the Form CMS-855B) or EFT information has changed. The provider should submit a Form CMS-855B to change this address; if the provider does not have an established enrollment record in the Provider Enrollment, Chain and Ownership System, it must complete an entire Form CMS-855B. The Durable Medical Equipment MAC is responsible for obtaining, updating and processing Form CMS-588 changes.

In situations where a provider is closing his/her/its business and has a termination date (e.g., he/she is retiring), the contractor will likely need to make payments for prior services rendered. Since the practice location has been terminated, the contractor may encounter a DNF message. If so, the contractor should request the provider to complete the “special payment” address section of the Form CMS-855B and to sign the certification statement. The contractor, however, shall not collect any other information unless there is a need to do so.

ii. Remittance Notices/Special Payments

For new enrollees, all payments must be made via EFT. The contractor shall thus ensure that the provider has completed and signed the Form CMS-588 and shall verify that the bank account is in compliance with Pub. 100-04, chapter 1, section 30.2.

If an enrolled provider that currently receives paper checks submits a Form CMS-855 change request – no matter what the change involves – the provider must also submit:

- A Form CMS-588 that switches its payment mechanism to EFT. (The change request cannot be processed until the Form CMS-588 is submitted.) All future payments (excluding special payments) must be made via EFT.
- The contractor shall also verify that the bank account is in compliance with Pub. 100-04, chapter 1, section 30.2.

(Once a provider changes its method of payment from paper checks to EFT, it must continue using EFT. A provider cannot switch from EFT to paper checks.)

The “special payment” address may only be one of the following:

- One of the provider’s practice locations
- A P.O. Box
- The provider’s billing agent. The contractor shall request additional information if it has any reason to suspect that the arrangement – at least with respect to any special payments that might be made – may violate the Payment to Agent rules in Pub. 100-04, chapter 1, section 30.2.
- Correspondence address
- A lockbox. The contractor shall request additional information if it has any reason to suspect that the arrangement, at least with respect to any special payments that might be made, may violate the Payment to Agent rules in Pub. 100-04, chapter 1, section 30.2.

iii. Out-of-State Practice Locations

If a supplier is adding a practice location in another State that is within the contractor’s jurisdiction, a separate, initial Form CMS-855B enrollment application is not required if the following 5 conditions are met:

- The location is not part of a separate organization (e.g., a separate corporation, partnership),
- The location does not have a separate tax identification number (TIN) and legal business name (LBN),
- The State in which the new location is being added does not require the location to be surveyed,

- The applicable RO does not require the new location or its owner to sign a separate supplier agreement, and
- The location is not an independent diagnostic testing facility (IDTFs are required to separately enroll each site)

Consider the following examples:

- The contractor's jurisdiction consists of States X, Y and Z. Jones Group Practice (JGP), Inc., is enrolled in State X with 3 locations. It wants to add a fourth location in State Y. The new location will be under JGP, Inc. JGP will not be establishing a separate corporation, LBN or TIN for the fourth location. Since there is no State or RO involvement with group practices, all 5 conditions are met. JGP can add the fourth location via a change of information request, rather than an initial application. The change request must include all information relevant to the new location (e.g., licensure, new managing employees). To the extent required, the contractor shall create a separate PECOS enrollment record for the State Y location.
- The contractor's jurisdiction consists of States X, Y and Z. Jones Group Practice (JGP), Inc., is enrolled in State X with 3 locations. It wants to add a fourth location in State Y, but under a newly created, separate entity - Jones Group Practice, LP. The fourth location must be enrolled via a separate, initial Form CMS-855B.
- The contractor's jurisdiction consists of States X, Y and Z. Jones Group Practice (JGP), Inc., is enrolled in State X with 3 locations. It wants to add a fourth location in State Q. Since State Q is not within the contractor's jurisdiction, a separate initial enrollment for the fourth location is necessary.
- The contractor's jurisdiction consists of States X, Y and Z. Jones Ambulatory Surgical Center (JASC), Inc., is enrolled in State X with 3 locations. It wants to add a fourth location in State Z under JASC, Inc. However, it has been determined that a separate survey and certification of the new site are required. A separate, initial Form CMS-855B is therefore necessary.

e. Ownership Interest and/or Managing Control Information (Section 5 & 6)

Regarding the Organizational Ownership Interest and/or Managing Control Information section of the Form CMS-855B Refer to Section 10.6.7(A) – Owning and Managing Organizations and section 10.6.7(C) – Tax Identification Numbers (TINs) of Owning and Managing Organizations and Individuals.

Regarding the Individual Ownership Interest and/or Managing Control Information section of the Form CMS-855B, refer to section 10.6.7(B) Owning and Managing Individuals and section 10.6.7(C) – Tax Identification Numbers (TINs) of Owning and Managing Organizations and Individuals.

f. Billing Agency Information (Section 8)

Regarding the Billing Agency Information section of the Form CMS-855B, refer to Section 10.6.8 of this chapter.

In addition, regarding the Billing Agency Information section of the Form CMS-855B, if the telephone number is blank, the number can be verified with the supplier by telephone, e-mail or fax. If the section is blank, including the check box, no additional development is necessary.

g. Contact Person (Section 13)

Regarding the Contact Person section of the Form CMS-855B, refer to Section 10.6.9 of this chapter.

If this section is completely blank, the contractor need not develop for this information and can simply contact an authorized or delegated official.

If neither box is checked but the contact person information is incomplete (e.g., no telephone number listed), the contractor can either: (1) develop for this information by telephone, e-mail or fax, or (2) contact an authorized or delegated official.

Currently there is no option on the CMS-855B form to delete a contact person. Therefore, contractors shall accept end dates of a contact person via phone, email, fax or mail from the individual provider, the Authorized or Delegation official, or a current contact person on file. Contractors shall document in the comment section in PECOS who requested the termination, how it was requested (email, phone or fax) and when it was requested. The addition of contact persons must still be reported via the appropriate CMS-855B form.

h. Penalties for Falsifying Information (Section 14)

Please refer to the Penalties for Falsifying Information section of the Form CMS-855B for an explanation of penalties that apply to providers and suppliers for deliberately furnishing false information in this application to gain or maintain enrollment in the Medicare program.

i. Certification Statement (Section 15)

Unless indicated otherwise below or in another CMS directive, the instructions in this subsection apply to (1) signatures on the paper Form CMS-855, (2) signatures on the certification statement for Internet-based Provider Enrollment, Chain and Ownership System (PECOS) applications, and (3) electronic signatures

Valid signatures include handwritten (wet) signatures in ink and digital/electronic signatures (digital or electronic signatures such as those created by digital signature options, created in software, such as Adobe) shall be accepted. Contractors shall contact their PEOG BFL for questions regarding electronic signatures.

All signatures (handwritten or digital) are valid and appropriate in regards to (1) signatures on the paper Form CMS-855B (2) uploaded signatures on the certification statement for Internet-based Provider Enrollment, Chain and Ownership System (PECOS) applications.

The provider may submit their certification statement via e-signature or paper to their contractor. See section 10.3.1(B)(1)(i)(i) and 10.3.1(B)(1)(i)(ii) for further instructions on certification statement submissions.

i. Paper Submissions

A signed certification statement shall accompany the paper CMS-855B application. If the provider submits an invalid certification statement or fails to submit a certification statement, the contractor shall still proceed with processing the application. An appropriate certification statement shall be solicited as part of the development process – preferably via email or fax. This includes certification statements that are: (a) unsigned; (b) undated; (c) was signed (as reflected by the date of signature) more than 120 days prior to the date on which the contractor received the application); (d) missing certification statements, or (e) stamped. The contractor shall send one development request to include a list of all of the missing required data/documentation, including the certification statement. The contractor may reject the provider’s application if the provider fails to furnish the missing information on the enrollment application - including all necessary documentation - within 30 calendar days from the date the contractor requested the missing information or documentation. Unless stated otherwise in this chapter or in another CMS directive:

- The contractor shall begin processing the application upon receipt and shall develop for missing certification statements and all other missing information, including application fee, upon review.
- The certification statement may be returned via scanned email or fax.
- Signature dates cannot be prior to 120 days of the receipt date of the application.
- For paper applications that require development, it is only necessary that the dated signature of at least one of the provider’s authorized or delegated officials be on the certification statement that must be sent in within 30 days; obtaining the signatures of the other authorized and delegated officials is not required.
- For paper changes of information applications (as the term “changes of information” is defined in section 10.4(J) of this chapter), if the certification statement is signed by an individual who is not on file with the contractor as being an authorized or delegated official of the provider, the contractor may accept the certification statement but shall develop for information on the person in question in accordance with section 10.3.1(B)(1)(i) of this chapter.
- The contractor is not required to compare the signature thereon with the same provider, authorized or delegated official’s signature on file to ensure that it is the same person. The contractor shall not request the submission of a driver’s license or passport to verify a signature.

ii. Certification Statement: Internet-based PECOS Submissions

If the provider submits its application online and chooses to submit its certification statement via paper rather than through e-signature, it shall do so via PECOS upload functionality. The provider shall not mail in its paper certification statement as it will not be accepted. Unless stated otherwise in this chapter or in another CMS directive:

- The contractor shall begin processing the application upon receipt and shall develop for missing certification statements and all other missing information, including application fee, upon review.
- Signature dates cannot be prior to 120 days of the receipt date of the application.
- If the provider submits an invalid certification statement, the contractor shall treat this as missing information and develop for a correct certification statement – preferably via email or fax. This includes certification statements that are: (a) unsigned; (b) undated; (c) was signed (as reflected by the date of signature) more than 120 days prior to the date on which the contractor received the application); (d) missing certification statements, or (e) stamped. The contractor shall send one development request to include a list of all of the missing required data/documentation, including the certification statement. The contractor may reject the provider’s application if the provider fails to furnish the missing 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 Internet-based PECOS applications that require development, it is only necessary that the dated signature of at least one of the provider’s authorized or delegated officials be on the certification statement that must be sent in within 30 days; obtaining the signatures of the other authorized and delegated officials is not required.
- For Internet-based PECOS changes of information applications (as the term “changes of information” is defined in section 10.4(J) of this chapter), if the certification statement is signed by an individual who is not on file with the contractor as being an authorized or delegated official of the provider, the contractor may accept the certification statement but shall develop for information on the person in question in accordance with section 10.3.1(B)(1)(i) of this chapter.
- The contractor is not required to compare the signature thereon with the same provider, authorized or delegated official’s signature on file to ensure that it is the same person. The contractor shall not request the submission of a driver’s license or passport to verify a signature.

iii. Certification Statement Development

If the provider submits an invalid certification statement (e.g., unsigned; undated; or stamped signature; signed more than 120 days of the receipt date, incorrect individual signed it; not all authorized officials signed it) or neglects to send a certification statement, the contractor shall treat this as missing information and develop for a correct certification statement using the procedures outlined in this chapter. The contractor shall send a development letter to the provider – preferably via email or fax.

Any development requests that require the submission of a newly signed certification statement may be submitted for paper applications via scanned email, fax, or mail; and for web applications by upload, fax, email or e-signature. Only the actual signature page is required; the additional page containing the certification terms need not be submitted. This also applies to the provider's initial submission of a certification statement; such instances require the submission of only the signature page and not the certification terms.

In addition, the Authorized Official's telephone number can be left blank. No further development is needed.

iv. Signatory Requirements

For Form CMS-855B initial applications, the certification statement must be signed and dated by an authorized official of the provider. (See section 10.1.1 of this chapter for a definition of "authorized official.") The provider can have an unlimited number of authorized officials, so long as each meets the definition of an authorized official. The Individual Ownership and/or Managing Control section of the Form CMS-855B must be completed for each authorized official.

The contractor shall notify the provider accordingly. If the person is not listed as a "Contracted Managing Employee" in the Individual Ownership and/or Managing Control section and the contractor has no reason to suspect that the person does not qualify as an authorized official, no further investigation is required. Should the contractor have doubts that the individual qualifies as an authorized official, it shall contact the official or the applicant's contact person to obtain more information about the official's job title and/or authority to bind. If the contractor remains unconvinced that the individual qualifies as an authorized official, it shall notify the provider that the person cannot be an authorized official. If that person is the only authorized official listed and the provider refuses to use a different authorized official, the contractor shall deny the application.

An authorized official must be a 5 percent direct owner, chairman of the board, etc., of the enrolling provider. One cannot use his/her status as the chief executive officer, chief financial officer, etc., of the provider's parent company, management company, or chain home office as a basis for his/her role as the provider's authorized official.

In addition:

- A. Deletion of Authorized Official - If an authorized official is being deleted, the contractor need not obtain (1) that official's signature, or (2) documentation verifying that the person is no longer an authorized official.
- B. Change in Authorized Officials - A change in authorized officials does not impact the authority of existing delegated officials to report changes and/or updates to the provider's enrollment data or to sign revalidation applications.
- C. Authorized Official Not on File - If the provider submits a change of information (e.g., change of address) and the authorized official signing the form is not on file, the contractor shall ensure that: (1) the person meets the definition of an authorized official, and (2) the Individual Ownership and/or

Managing Control section of the Form CMS-855B is completed for that person. The signature of an existing authorized official is not needed in order to add a new authorized official. Note that the original change request and the addition of the new official shall be treated as a single change request (i.e., one change request encompassing two different actions) for purpose of enrollment processing and reporting.

D. Effective Date - The effective date in the Provider Enrollment, Chain and Ownership System for the Certification Statement (for Authorized Officials) section of the Form CMS-855B should be the date of signature.

E. Social Security Number - To be an authorized official, the person must have and must submit his/her social security number (SSN). An Individual Taxpayer Identification Number (ITIN) cannot be used in lieu of an SSN in this regard.

F. Identifying the Provider – As stated earlier, an authorized official must be an authorized official of the provider, not of an owning organization, parent company, chain home office, or management company. Identifying the provider is not - for purposes of determining an authorized official's qualifications - determined solely by the provider's tax identification number (TIN). Rather, the organizational structure is the central factor. For instance, suppose that a chain drug store, Company X, wants to enroll 100 of its pharmacies with the contractor. Each pharmacy has a separate TIN and must therefore enroll separately. Yet all of the pharmacies are part of a single corporate entity – Company X. In other words, there are not 100 separate corporations in our scenario, but merely one corporation whose individual locations have different TINs. Here, an authorized official for Pharmacy #76, can be someone at X's headquarters (assuming that the definition of authorized official is otherwise met), even though this main office might be operating under a TIN that is different from that of #76. This is because headquarters and Pharmacy #76 are part of the same organization/corporation. Conversely, if #76 was a corporation that was separate and distinct from Company X, only individuals that were part of #76 could be authorized officials.

G. Certification Statement Development – When the contractor develops for missing or additional information and the provider must submit a newly-signed certification statement, only the actual signature page is required; the additional page containing the certification terms need not be submitted unless the contractor requests it. This applies to the provider's initial submission of a certification statement for a particular application as well; such instances do not require the submission of both the signature page and the page containing the certification terms.

v. Authorized Officials

An authorized official must be a 5 percent direct owner, chairman of the board, etc., of the enrolling provider with the authority to bind the provider or supplier, both legally and financially, to the requirements set forth in 42 CFR §424.510. This person must also have an ownership or control interest in the provider or supplier, such as, the general partner, chairman of the board, chief financial officer, chief executive officer, president,

or hold a position of similar status and authority within the provider or supplier organization. One cannot use his/her status as the chief executive officer, chief financial officer, etc., of the provider's parent company, management company, or chain home office as a basis for his/her role as the provider's authorized official.

An authorized official is an appointed official (for example, chief executive officer, chief financial officer, general partner, chairman of the board, or direct owner) to whom the organization has granted the legal authority to enroll it in the Medicare program, to make changes or updates to the organization's status in the Medicare program, and to commit the organization to fully abide by the statutes, regulations, and program instructions of the Medicare program. An AO is not restricted to the examples of the titles outlined above but is applicable to an equivalent that is an appointed official to whom the organization has granted the legal authority to act on behalf of the organization. These additional titles could include, but are not limited to, executive directors, administrator, president, vice president. Contractors shall consider the individual's title as well as the authority granted by the organization when determining whether an individual qualifies as an AO when processing enrollment applications. If the contractor is unsure of an AO's qualifications or authority, they shall contact their Provider Enrollment & Oversight Group Business Function Lead (PEOG BFL) for further clarification. The contractor shall obtain PEOG BFL approval if the only role of the listed AO is "Contracted Managing Employee" despite title and other qualifications, the BFL will confirm authority.

If an authorized official is listed as a "Contracted Managing Employee" in the Individual Ownership and/or Managing Control section of the Form CMS-855B and does not qualify as an authorized official under some other category in the Individual Ownership and/or Managing Control section, he/she cannot be an authorized official. The contractor shall notify the provider accordingly. If the person is not listed as a "Contracted Managing Employee" in the Individual Ownership and/or Managing Control section and the contractor has no reason to suspect that the person does not qualify as an authorized official, no further investigation is required. Should the contractor have doubts that the individual qualifies as an authorized official, it shall contact the official or the applicant's contact person to obtain more information about the official's job title and/or authority to bind. If the contractor remains unconvinced that the individual qualifies as an authorized official, it shall notify the provider that the person cannot be an authorized official. If that person is the only authorized official listed and the provider refuses to use a different authorized official, the contractor shall deny the application.

For Form CMS-855B initial applications, the certification statement must be signed and dated by an authorized official of the provider or supplier. (See section 10.1.1 and 10.3.1(B)(1)(i) of this chapter for a definition of "authorized official."). This applies to: (1) signatures on the paper Form CMS-855B, (2) signatures on the certification statement for Internet-based Provider Enrollment, and electronic signatures.

For Form CMS-855B applications submitted to change, update and/or revalidate the provider or supplier's Medicare enrollment data, the certification statement may be signed and dated by the authorized or delegated official of the provider or supplier. This applies to: (1) signatures on the paper Form CMS-855B, (2) signatures on the certification statement for Internet-based Provider Enrollment, and electronic signatures.

vi. Deletions of Authorized Official

If an authorized official is being deleted, the contractor need not obtain (1) that official's signature, or (2) documentation verifying that the person is no longer an authorized official.

vii. Change in Authorized Officials

A change in authorized officials does not impact the authority of existing delegated officials to report changes and/or updates to the provider's enrollment data or to sign revalidation applications.

viii. Authorized Official Not on File

If the provider submits a change of information (e.g., change of address) and the authorized official signing the form is not on file, the contractor shall ensure that: (1) the person meets the definition of an authorized official, and (2) the Individual Ownership and/or Managing Control section of the Form CMS-855B is completed for that person. The signature of an existing authorized official is not needed in order to add a new authorized official. Note that the original change request and the addition of the new official shall be treated as a single change request (i.e., one change request encompassing two different actions) for purpose of enrollment processing and reporting.

ix. Effective Date

The effective date in the Provider Enrollment, Chain and Ownership System for the Certification Statement (for Authorized Officials) section of the Form CMS-855B should be the date of signature.

x. Social Security Number

To be an authorized official, the person must have and must submit his/her social security number (SSN). An Individual Taxpayer Identification Number (ITIN) cannot be used in lieu of an SSN in this regard.

xi. Identifying the Provider

As stated earlier, an authorized official must be an authorized official of the provider, not of an owning organization, parent company, chain home office, or management company. Identifying the provider is not - for purposes of determining an authorized official's qualifications - determined solely by the provider's tax identification number (TIN). Rather, the organizational structure is the central factor. For instance, suppose that a chain drug store, Company X, wants to enroll 100 of its pharmacies with the contractor. Each pharmacy has a separate TIN and must therefore enroll separately. Yet all of the pharmacies are part of a single corporate entity – Company X. In other words, there are not 100 separate corporations in our scenario, but merely one corporation whose individual locations have different TINs. Here, an authorized official for Pharmacy #76, can be someone at X's headquarters (assuming that the definition of authorized official is otherwise met), even though this main office might be operating under a TIN that is different from that of #76. This is because headquarters and Pharmacy #76 are part of the same organization/corporation. Conversely, if #76 was a corporation that was separate and distinct from Company X, only individuals that were part of #76 could be authorized officials.

j. Delegated Officials (Section 16)

A delegated official is an individual to whom an authorized official listed in the Certification Statement section of the Form CMS-855 delegates the authority to report changes and updates to the provider's enrollment record or to sign revalidation applications. The delegated official's signature binds the organization both legally and financially, as if the signature was that of the authorized official. Before the delegation of authority is established, the only acceptable signature on the enrollment application to report updates or changes to the enrollment information is that of the authorized official currently on file with Medicare. The delegated official must be an individual with an "ownership or control interest" in (as that term is defined in §1124(a)(3) of the Social Security Act), or be a W-2 managing employee of the provider.

Section 1124(a)(3) defines an individual with an ownership or control interest as:

- A five percent direct or indirect owner of the provider,
- An officer or director of the provider (if the provider is a corporation), or
- Someone with a partnership interest in the provider, if the provider is a partnership

The delegated official must be a delegated official of the provider, not of an owning organization, parent company, chain home office, or management company. One cannot use his/her status as a W-2 managing employee of the provider's parent company, management company, or chain home office as a basis for his/her role as the provider's delegated official.

The Ownership Interest and Managing Control Information in the Individual Ownership and/or Managing Control section of Form CMS-855B must be completed for all delegated officials.

A delegated official has no authority to sign an initial application. However, the delegated official may (i) sign a revalidation application and (ii) sign off on changes/updates submitted in response to a contractor's request to clarify or submit information needed to continue processing the provider's initial application.

Further Delegation - Delegated officials may not delegate their authority to any other individual. Only an authorized official may delegate the authority to make changes and/or updates to the provider's Medicare data or to sign revalidation applications.

Regarding managing employees, for purposes of the Delegated Officials information captured in the Delegated Officials section only, the term "managing employee" means any individual, including a general manager, business manager, or administrator, who exercises operational or managerial control over the provider, or who conducts the day-to-day operations of the provider. However, this does not include persons who, either under contract or through some other arrangement, manage the day-to-day operations of the provider but who are not actual W-2 employees. For instance, suppose the provider hires Joe Smith as an independent contractor to run its day-to-day operations. Under the definition of "managing employee" in the Individual Ownership and/or Managing Control section of the Form CMS-855B, Smith would have to be listed in that section. Yet under the Delegated Officials section definition (as described above), Smith cannot be a delegated

official because he is not an actual W-2 employee of the provider. Independent contractors are not considered "managing employees" under the Delegated Officials section of the Form CMS-855B.

i. W-2 Form

Unless the contractor requests it to do so, the provider is not required to submit a copy of the owning/managing individual's W-2 to verify an employment relationship.

ii. Number of Delegated Officials

The provider can have as many delegated officials as it chooses. Conversely, the provider is not required to have any delegated officials. Should no delegated officials be listed, the authorized official(s) remains the only individual(s) who can report changes and/or updates to the provider's enrollment data.

iii. Effective Date

The effective date in PECOS for the Delegated Officials section of the Form CMS-855B should be the date of signature.

iv. Social Security Number

To be a delegated official, the person must have and must submit his/her social security number. An Individual Taxpayer Identification Number (ITIN) cannot be used in lieu of an SSN in this regard.

v. Deletion of a Delegated Official

If a delegated official is being deleted, documentation verifying that the person no longer is or qualifies as a delegated official is not required. Also, the signature of the deleted official is not needed.

vi. Delegated Official Not on File

If the provider submits a change of information (e.g., change of address) and the delegated official signing the form is not on file, the contractor shall ensure that (1) the person meets the definition of a delegated official, (2) the Individual Ownership and/or Managing Control section of the Form CMS-855B is completed for that person, and (3) an authorized official signs off on the addition of the delegated official. (NOTE: The original change request and the addition of the new official shall be treated as a single change request (i.e., one change request encompassing two different actions) for purpose of enrollment processing and reporting.)

vii. Signature on Paper Application

If the provider submits a paper Form CMS-855B change request, the contractor may accept the signature of a delegated official in the Certification Statement or Delegated Officials Sections of the Form CMS-855B.

In addition, the Delegated Official's telephone number can be left blank. No further development is needed.

k. Supporting Documents (Section 17)

Refer to the Supporting Documents Section of the CMS Form-855B for information concerning supporting documents.

l. Attachment 1 for Ambulance Service Suppliers

Regarding Attachment 1 of the Form CMS-855B, refer to 10.2.2(G).

In addition, in section D of Attachment 1 of the Form CMS-855B, the “Land,” “Air,” and “Marine” boxes need not be checked (or developed) if the type of vehicle involved is clear.

Contractors are not required to develop for the written statement from the supplier, signed by the President, Chief Executive Officer or Chief Operating Officer of the airport from where the aircraft is hangared that gives the name and address of the facility.

m. Attachment 2 for Independent Diagnostic Testing Facilities

Regarding Attachment 2 of the Form CMS-855B, refer to 10.2.2(I).

2. Additional Processing Information and Alternatives

a. Unsolicited Additional Information

Regarding unsolicited additional information, if the provider submits missing/clarifying data or documentation on its own volition (i.e., without being contacted by the contractor), the contractor shall include this additional data/documentation in its overall application review. Any new or changed information that a provider submits prior to the date the contractor finishes processing a previously submitted change request is no longer considered to be an update to that change request. Rather, it is considered to be and shall be processed as a separate change request. The contractor may process both changes simultaneously, but the change that was submitted first shall be processed to completion prior to the second one being processed to completion.

b. Provider-Based Entities

The contractor shall adhere to the following regarding the enrollment of provider-based entities:

- **Group Practice Initially Enrolling** – If a group practice is enrolling in Medicare and will become provider-based to a hospital, the group generally must enroll via the Form CMS-855B if it wants to bill for practitioner services. The group would also need to be listed or added as a practice location on the hospital’s Form CMS-855A.
- **Group Practice Changing from Provider-Based to Freestanding** – In this situation, the hospital should submit a Form CMS-855A change request that deletes the clinic as a practice location. The group may also need to change the type of clinic it is enrolled as; this may require a new Form CMS-855B.
- **Group Practice Changing from Freestanding to Provider-Based** – Here, the hospital must submit a Form CMS-855A change request adding the group as a practice location. The group may also need to change the type of clinic it is enrolled as; this may require a new Form CMS-855B.

- Unless the CMS regional office (RO) dictates otherwise, the contractor shall not delay the processing of any practice location addition applications pending receipt of provider-based attestations or RO approval of provider-based status.

c. Information Disclosed Elsewhere

If a data element on the supplier's Form CMS-855B application is missing but the information is disclosed: (1) elsewhere on the application or (2) in the supporting documentation submitted with the application, the contractor need not obtain the missing data via an updated Form CMS-855B page and a newly-signed certification statement; no further development – not even by telephone – is required. The following information, however, must be furnished in the appropriate section(s) of the Form CMS-855B, even if the data is identified elsewhere on the form or in the supporting documentation:

- All ownership and managing control information in the Organizational or Individual Ownership and/or Managing Control sections of the Form CMS-855B
- Any final adverse action data requested in the Final Adverse Legal Actions/Convictions Section (sections 3) and the Organizational and Individual Ownership and/or Managing Control/Final Adverse Legal Action History sections of the Form CMS-855B
- The applicant's legal business names (LBN) or legal names
Note: If an application is submitted with a valid NPI and PTAN combination, but the LBN field is blank, an incomplete or inaccurate LBN is submitted, or the applicant includes a DBA name in the Practice Location Information section of the Form CMS-855B and the contractor is able to confirm the correct LBN based on the NPI and PTAN combination provided, the contractor is not required to develop.
- Tax identification numbers (TIN)
- NPI-legacy number combinations in the Practice Location Information section of the Form CMS-855B
Note: MACs may use the shared systems, PECOS or their provider files as a resource to determine the PTAN or NPI before developing to the provider.
- Supplier type in the Identifying Information section of the Form CMS-855B

If the supporting documentation currently exists in the provider's file, the provider or supplier is not required to submit that documentation again during the enrollment process. The MAC shall utilize the existing documentation for verification. Documentation submitted with a previously submitted enrollment application, or documentation currently uploaded in PECOS, qualifies as a processing alternative, unless stated otherwise in this chapter or any CMS directive. Also, per section 10.6.19(H) of this chapter, the contractor shall document in the provider file that the missing information was found elsewhere in the enrollment package. This excludes information that must be verified at the current point in time (i.e. a license without a primary source verification method). Additionally, contractors shall not utilize information submitted along with opt-out applications for enrollment application processing or vice-versa.

d. City, State, and ZIP Code

If an address (e.g., correspondence address, practice location) lacks a city, state or zip + four, the contractor can verify the missing data in any manner it chooses. In addition, the contractor can obtain the zip + four from either the U.S. Postal Service or the Delivery Point Validation in PECOS.

e. Inapplicable Questions

The supplier need not check “no” for questions that obviously do not apply to its supplier type.

f. Authorized/Delegated Official Telephone Number

The telephone number in these section can be left blank. No further development is needed.

C. CMS-855I - Medicare Enrollment Application for Physicians and Non-Physician Practitioners

This application should be completed by physicians and non-physician practitioners who render Medicare Part B services to beneficiaries. (This includes a physician or practitioner who: (1) is the sole owner of a professional corporation, professional association, or limited liability company, and (2) will bill Medicare through this business entity.)

1. Sections of the CMS-855I

a. Basic Information (Section 1)

In this section, the provider or supplier indicates the reason for submittal of the application. Unless otherwise stated in this chapter or in another CMS directive, the provider may only check one reason for submittal.

For example, suppose a supplier is deactivating one enrollment as one provider type and enrolling as a different provider type – both transactions cannot be reported on the same application.

With the exception of the voluntary termination checkbox and the effective date of termination checkbox in the Basic Information section of the Form CMS-855I, any blank data/checkboxes in the Basic Information section can be verified through any means chosen by the contractor (e.g., e-mail, telephone, fax).

i. Voluntary Withdrawal Reminder

When a practitioner submits a CMS-855I application to either: (1) add a practice location in a new State, or (2) relocate to a new State entirely, the contractor that received the application shall determine whether the practitioner still has an active PECOS enrollment record in the “other” State(s). If PECOS indeed indicates that the individual has an active practice location in the other State(s), the contractor should remind the practitioner that if he/she no longer intends to practice in that State, he/she must submit a CMS-855I voluntary termination application to the contractor for that jurisdiction. The reminder should be given in the approval letter that the receiving

contractor sends to the practitioner or, if more appropriate, in an e-mail or other form of written correspondence.

ii. Break in Medical Practice

If the contractor receives a CMS-855I from a practitioner who was once enrolled in Medicare but who has not been enrolled with any Medicare contractor for the previous 2 years, the contractor shall verify with the State where the practitioner last worked whether the practitioner was convicted of a felony or had his or her license suspended or revoked. If such an adverse action was imposed, the contractor shall take action in accordance with the instructions in this chapter.

b. Personal Identifying Information (Section 2)

Regarding licensure information in the Personal Identifying Information (License/Certification/Registration Information) section of the Form CMS-855I, the extent to which the applicant must complete the licensure information depends upon the provider type involved. Requirements vary by supplier type and by location, for instance, some states may require a particular supplier-type to be “certified” but not “licensed,” or vice versa. In general, individual suppliers (e.g. physicians and non-physician practitioners) complete information regarding licensure (a check box “License Not Applicable” is provided to reflect those instances where a state does not require licensure).

The only licenses that must be submitted with the application are those required by Medicare or the state to function as the supplier type in question. Licenses and permits that are not of a medical nature are not required. In addition, there may be instances where the supplier is not required to be licensed at all in a particular state; the contractor shall still ensure, however, that the supplier meets all applicable state and Medicare requirements.

The contractor shall verify that the supplier is licensed and/or certified to furnish services in:

- The state where the supplier is enrolling.
- Any other state within the contractor’s jurisdiction in which the supplier (per the “Practice Location Information” section of the Form CMS-855I) will maintain a practice location.

The contractor shall also adhere to the following:

i. Notarization

If the applicant submits a license that is not notarized or "certified true," the contractor shall verify the license with the appropriate state agency. (A notarized copy of an original document has a stamp that says "official seal," along with the name of the notary public, the state, the county, and the date the notary's commission expires. A certified "true copy" of an original document has a raised seal that identifies the state and county in which it originated or is stored.)

ii. Temporary Licenses

If the supplier submits a temporary license, the contractor shall note the expiration date in PECOS. Should the supplier fail to submit the permanent license after the temporary

license expiration date, the contractor shall initiate revocation procedures. (A temporary permit – one in which the applicant is not yet fully licensed and must complete a specified number of hours of practice in order to obtain the license – is not acceptable.)

iii. Revoked/Suspended Licenses

If the applicant had a previously revoked or suspended license reinstated, the applicant must submit a copy of the reinstatement notice with the application.

iv. License Expiration/Revocation Dates for Non-Certified Suppliers

For expired licenses, the contractor shall enter into PECOS the day after the expiration as the expiration date. For revoked and suspended licenses, the contractor shall enter into PECOS the revocation date (not the day after) as the expiration date.

See section 10.6.19(T)(1)(a) of this chapter for special instructions related to periodic license reviews and certain program integrity matters.

Regarding accreditation, as applicable based upon provider type, if the provider checks “Yes,” the contractor shall ensure that the listed accrediting body is one that CMS recognizes in lieu of a State survey or other certification for the provider type in question. If the accrediting body is not recognized by CMS, the contractor shall advise the provider accordingly.

v. Correspondence Address, Medical Record Correspondence Address and Telephone Number

Regarding the correspondence address required in the Personal Identifying Information (Correspondence Mailing Address) section of the Form CMS-855I, 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. The contractor is not required to verify the correspondence address. It cannot be the address of a billing agency, management services organization, 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.

Regarding the medical records correspondence address required in Personal Identifying Information (Medical Record Correspondence Address) section of the Form CMS-855I, the medical records correspondence address must be one where the contractor can directly contact the applicant regarding medical records once the provider is enrolled in the Medicare program. The contractor is not required to verify the medical records correspondence address. It cannot be the address of a billing agency, management services organization, 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. Note: the Medical Records Correspondence Address does not apply to individuals reassigning all benefits.

The provider may list any telephone number it wishes as the correspondence or medical record correspondence phone number. The number need not link to the listed correspondence address. If the provider fails to list a correspondence or medical record telephone number and it is required for the application submission, the contractor shall develop for this information – preferably via email or fax. The contractor shall accept a

particular phone number if it has no reason to suspect that it does not belong to or is not somehow associated with the provider. The contractor is not required to verify the telephone number.

Regarding unavoidable Phone Number or Address Changes, unless CMS specifies otherwise, any change in the provider's phone number or address that the provider did not cause (i.e., area code change, municipality renames the provider's street) must still be updated via the Form CMS-855I.

vi. 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.

vii. Specialties

On the Form CMS-855I, under the Personal Identifying Information (Physician Specialty) section, the physician must indicate his/her supplier specialty, using a checkmark, an "X," or other symbol. If the physician has more than one specialty, the physician must indicate his/her supplier specialties, showing "P" for primary and "S" for secondary. Non-physician practitioners must indicate their supplier type.

The contractor shall validate that any provider identifying a secondary specialty on the CMS-855I application has the appropriate medical license. The contractor shall validate the license using the state's medical license website. If an active license is not found, the contractor shall develop via telephone, fax, email, or mail to confirm the provider's intent and to obtain a copy of the license, if applicable.

The contractor shall deny the application if the individual fails to meet the requirements of his/her physician specialty (primary and/or secondary) or supplier type.

Regarding education for non-physician practitioners, the contractor shall verify all required educational information for non-physician practitioners. While the non-physician practitioner must meet all Federal and State requirements, he/she need not provide documentation of courses or degrees taken to satisfy these requirements unless specifically requested to do so by the contractor. To the maximum extent possible, the contractor shall use means other than the practitioner's submission of documentation- such as a State or school Web site - to validate the person's educational qualifications.

A physician need not submit a copy of his/her degree unless specifically requested to do so by the contractor. To the maximum extent possible, the contractor shall use means other than the physician's submission of documentation- such as a State or school Web site - to validate the person's educational status.

viii. Relocation to a New State: License Reviews

When a practitioner submits a CMS-855I application to either: (1) add a practice location in a new State, or (2) relocate to a new State entirely, the contractor that received the application shall review State licensing board information for the "prior" State to determine:

- Whether the practitioner had his or her medical license revoked, suspended, or inactive (due to retirement, death, or voluntary surrender of license), or otherwise lost his or her license, and
- If the practitioner has indeed lost his or her medical license, whether he or she reported this information to Medicare via the CMS-855I within the timeframe specified in 42 CFR §424.520.

If the practitioner is currently enrolled and did not report the adverse action to Medicare in a timely manner, the contractor shall revoke the practitioner's Medicare billing privileges and establish the appropriate length enrollment bar. If the practitioner is submitting an initial enrollment application (e.g., is moving to a new State and contractor jurisdiction) and did not report the adverse action in section 3 of the CMS-855I, the contractor shall deny the enrollment application.

c. Final Adverse Legal Actions/Convictions (Section 3)

Refer to section 10.6.6 of this chapter for information regarding final adverse actions.

d. Business Information (Section 4)

Unless CMS specifies otherwise, any change in the provider's phone number or address that the provider did not cause (i.e., area code change, municipality renames the provider's street) must still be updated via the Form CMS-855I.

Any provider submitting a Form CMS-855I application must submit the 9-digit ZIP Code for each practice location listed.

Regarding the contractor's verification of practice locations, the contractor shall verify that the practice locations listed on the application actually exist and is a valid address with the United States Postal Service (USPS). PECOS includes a USPS Address Matching System Application Program Interface (API), which validates address information entered and flags the address if it is determined to be invalid, unknown, undeliverable, vacant, unlikely to deliver mail (No-Stat), a CMRA (i.e., UPS Store, mailboxes, etc.) or a known invalid address false positive. These address types are not permitted in PECOS and are flagged upon entry.

The contractor shall also verify that the reported telephone number is operational and connects to the practice location/business listed on the application. However, the contractor need not contact every location for applicants that are enrolling multiple locations; the contractor can verify each location's telephone number with the contact person listed on the application and note the verification accordingly in the contractor's verification documentation per section 10.6.19(H) of this chapter. (The telephone number must be one where patients and/or customers can reach the applicant to ask questions or register complaints.) The contractor may also match the applicant's telephone number with known, in-service telephone numbers - via, for instance, the Yellow Pages or the Internet - to correlate telephone numbers with addresses. If the applicant uses his/her/its cell phone for their business, the contractor shall verify that this is a telephone connected directly to the business. If the contractor cannot verify the telephone number, it shall request clarifying information from the applicant; the inability to confirm a telephone number may indicate that an onsite visit is necessary. In some instances, a 1-800 number or out-of-state

number may be acceptable if the applicant's business location is in another State but his/her/its practice locations are within the contractor's jurisdiction.

In section 4A, if the "type of practice location" checkbox is blank, the contractor can confirm the information via e-mail or fax.

The practice location address in the Practice Location Information section must be a valid address with the United States Postal Service (USPS). Addresses entered into PECOS are verified via computer software to determine if they are valid and deliverable.

In the Practice Location Information/Remittance Notices/Special Payments Mailing Address section, if neither box is checked and no address is provided, the contractor can contact the supplier by telephone, e-mail or fax to confirm the supplier's intentions. If the "special payments" address is the same as the practice location, no further development is needed. If, however, the supplier wants payments to be sent to a different address, the address in the Remittance Notices/Special Payments Mailing Address section must be completed via the Form CMS-855I. Each practice location is to be verified. However, there is no need to separately contact each location on the application. Such verification can be done via the contact person listed on the application; the contact person's verification shall be documented in the provider file pursuant to section 10.6.19(H) of this chapter.

A practitioner who only renders services in patients' homes (i.e., house calls) must supply his/her home address in the Practice Location Information/Rendering Services in Patients' Homes section. In addition, if a practitioner renders services in a retirement or assisted living community, the Practice Location Information section must include the name and address of that community. In either case, the contractor shall verify that the address is a physical address. Post office boxes and drop boxes are not acceptable.

If the physician or non-physician practitioner uses his/her home address as their practice location and exclusively performs services in patients' homes, nursing homes, etc., no site visit is necessary.

If an individual practitioner: (1) is adding a practice location and (2) is normally required to complete a questionnaire in the Personal Identifying Information section of the Form CMS-855I specific to its supplier type (i.e.: physical therapists), the person or entity must submit an updated questionnaire to incorporate services rendered at the new location.

For suppliers paid via the Multi-Carrier System (MCS), the practice location name entered into PECOS shall be the legal business name.

i. Do Not Forward (DNF)

Unless instructed otherwise in another CMS directive, the contractor shall follow the DNF initiative instructions in Pub. 100-04, chapter 1, section 80.5. Returned paper checks, remittance notices, or EFT payments shall be flagged if returned from the post office or banking institution, respectively, as this may indicate that the provider's "special payment" address (Business Information of the Form CMS-855I) or EFT information has changed. The provider should submit a Form CMS-855I to change this address; if the provider does not have an established enrollment record in the Provider Enrollment, Chain and Ownership System, it must complete an entire Form CMS-855I

and Form CMS-588. The Durable Medical Equipment MAC is responsible for obtaining, updating and processing Form CMS-588 changes.

In situations where a provider is closing his/her/its business and has a termination date (e.g., he/she is retiring), the contractor will likely need to make payments for prior services rendered. Since the practice location has been terminated, the contractor may encounter a DNF message. If so, the contractor should request the provider to complete the “special payment” address section of the Form CMS-855I and to sign the certification statement. The contractor, however, shall not collect any other information unless there is a need to do so.

ii. Remittance Notices/Special Payments

For new enrollees, all payments must be made via EFT. The contractor shall thus ensure that the provider has completed and signed the Form CMS-588 and shall verify that the bank account is in compliance with Pub. 100-04, chapter 1, section 30.2.

If an enrolled provider that currently receives paper checks submits a Form CMS-855I change request – no matter what the change involves – the provider must also submit:

- A Form CMS-588 that switches its payment mechanism to EFT. (The change request cannot be processed until the Form CMS-588 is submitted.) All future payments (excluding special payments) must be made via EFT.
- The contractor shall also verify that the bank account is in compliance with Pub. 100-04, chapter 1, section 30.2.

(Once a provider changes its method of payment from paper checks to EFT, it must continue using EFT. A provider cannot switch from EFT to paper checks.)

The “special payment” address may only be one of the following:

- One of the provider’s practice locations
- A P.O. Box
- A Lockbox. The contractor shall request additional information if it has any reason to suspect that the arrangement, at least with respect to any special payments that might be made, may violate the Payment to Agent rules in Pub. 100-04, chapter 1, section 30.2.
- The provider’s billing agent. The contractor shall request additional information if it has any reason to suspect that the arrangement – at least with respect to any special payments that might be made – may violate the Payment to Agent rules in Pub. 100-04, chapter 1, section 30.2.
- Correspondence address

iii. Solely-Owned Organizations

All pertinent data for sole-owned organizations can be furnished via the CMS-855I alone. The contractor, however, shall require the supplier to submit a CMS-855B, CMS-855I and CMS-855R if, during the verification process, it discovers that the supplier is not a solely-owned organization. (**NOTE:** A solely-owned supplier type that normally completes the CMS-855B to enroll in Medicare must still do so. For example, a solely-owned LLC that is an ambulance company must complete the CMS-855B, even though the Practice Location Information/Sole Proprietor/Sole Proprietorship section makes mention of solely-owned LLCs. Use of the Practice Location Information section of CMS-855I is limited to suppliers that perform physician or practitioner services.)

Sole proprietorships need not complete Business Information of the CMS-855I. By definition, a sole proprietorship is not a corporation, professional association, etc. Do not confuse a sole proprietor with a physician whose business is that of a corporation, LLC, etc., of which he/she is the sole owner.

In the Business Information, the supplier may list a type of business organization other than a professional corporation, a professional association, or a limited liability company (e.g., closely-held corporation). This is acceptable so long as that business type is recognized by the State in which the supplier is located.

The contractor shall verify all data furnished in the Business Information section (e.g., legal business name, TIN, adverse legal actions). If the Business Information section is left blank, the contractor may assume that it does not pertain to the applicant.

A solely-owned physician or practitioner organization that utilizes the Business Information section to enroll in Medicare can generally submit change of information requests to Medicare via the CMS-855I. However, if the change involves data not captured on the CMS-855I, the change must be made on the applicable CMS form (i.e., CMS-855B, CMS-855R).

iv. Individual Reassignment/Affiliation Information

If the applicant indicates that he/she intends to render all or part of his/her services in a private practice, clinic/group or any organization to which he/she would reassign benefits, the contractor shall ensure that the applicant (or the group or organization) has submitted a CMS-855R for each individual, clinic/group practice or organization to which the individual plans to reassign benefits. The contractor shall also verify that the individual, clinic/group practice or organization is enrolled in Medicare. If it is not, the contractor shall enroll the individual, clinic/group practice or organization prior to approving the reassignment.

v. Sole Proprietor Use of EIN

The practitioner may obtain a separate EIN if he/she wants to receive reassigned benefits as a sole proprietor.

vi. NPI Information for Groups

If an individual, clinic/group practice or organization is already established in PECOS (i.e., status of "approved" unless the CMS-855I is submitted for the purpose of revalidation), the physician or non-physician practitioner is not required to submit the NPI in 4F of the 855I. In short, if the individual, clinic/group practice or organization is

already established in PECOS, the individual, clinic/group practice or organization does not need to include an NPI in the Business Information/Individual Reassignment/Affiliation Information section. The only NPI that the physician or non-physician practitioner must supply is the NPI found in the Personal Identifying Information (Individual Information) section.

NOTE: Physicians and non-physician practitioners are required to supply the NPI in the Business Information/Individual Reassignment/Affiliation Information section of the CMS-855I for individuals/groups/organizations not established in PECOS with a status of "approved."

vii. Out-of-State Practice Locations

If a supplier is adding a practice location in another State, a separate, initial Form CMS-855I enrollment application is required for that location even if:

- The location is part of the same organization (e.g., a solely-owned corporation),
- The location has the same tax identification number (TIN) and legal business name (LBN), and
- The location is in the same contractor jurisdiction.

To illustrate, suppose the contractor's jurisdiction consists of States X, Y and Z. Dr. Jones, a sole proprietor, is enrolled in State X with 2 locations. He wants to add a third location in State Y under his social security number and his sole proprietorship's employer identification number. A separate, initial Form CMS-855I application is required for the State Y location.

e. Individuals Having Managing Control (Section 6)

Regarding the Managing Employee Information section of the Form CMS-855I, refer to section 10.6.7(B) Owning and Managing Individuals and section 10.6.7(C) – Tax Identification Numbers (TINs) of Owning and Managing Organizations and Individuals.

f. Billing Agency Information (Section 8)

Regarding the Billing Agency section of the Form CMS-855I, refer to Section 10.6.8 of this chapter.

In addition, if the telephone number is blank, the number can be verified with the supplier by telephone, e-mail or fax. If the section is blank, including the check box, no additional development is necessary.

g. Supporting Documents (Section 12)

Refer to the Supporting Documents section of the CMS Form-855I for information concerning supporting documents.

h. Contact Persons (Section 13)

Regarding the Contact Persons section of the Form CMS-855I, refer to Section 10.6.9 of this chapter.

In addition,

- If this section is completely blank, the contractor need not develop for this information and can simply contact the physician/practitioner).
- If the Contact the individual listed in Section 2A checkbox is checked but the contact person information is incomplete (e.g., no telephone number listed), the contractor can either: (1) develop for this information by telephone, e-mail or fax, or (2) contact the physician/practitioner.

i. Penalties for Falsifying Information (Section 14)

Please refer to Penalties for Falsifying Information section of the Form CMS-855I for an explanation of penalties that apply to providers and suppliers for deliberately furnishing false information in this application to gain or maintain enrollment in the Medicare program.

j. Certification Statement (Section 15)

Unless otherwise specified, the instructions in section 10.3.1(C)(1)(h) apply to: (1) signatures on the paper Form CMS-855I, (2) signatures on the certification statement for Internet-based Provider Enrollment, Chain and Ownership System (PECOS) applications, and (3) electronic signatures.

Valid signatures include handwritten (wet) signatures in ink and digital/electronic signatures (digital or electronic signatures such as those created by digital signature options, created in software, such as Adobe) shall be accepted. Contractors shall contact their PEOG BFL for questions regarding electronic signatures.

Regarding the Certification Statement section of the Form CMS-855I, the enrolling or enrolled physician or non-physician practitioner is the only person who can sign the Form CMS-855I. (This applies to initial enrollments, changes of information, reactivations, etc.) This includes solely-owned entities listed in the Business Information/Individual Reassignment/Affiliation Information section of the Form CMS-855I. A physician or non-physician practitioner may not delegate the authority to sign the Form CMS-855I on his/her behalf to any other person.

The enrolling or enrolled physician or non-physician practitioner is the only person who can sign the Form CMS-855I (This applies to initial enrollments, changes of information, reactivations, revalidations, voluntary withdrawals, etc.). This includes solely-owned entities listed in the Business Information section of the Form CMS-855I. A physician or non-physician practitioner may not delegate the authority to sign the Form CMS-855I on his/her behalf to any other person. This applies to: (1) signatures on the paper Form CMS-855I, (2) signatures on the certification statement for Internet-based Provider Enrollment, and electronic signatures.

Note: In the case of death, an executor of the estate, may sign on behalf of the deceased provider. This would only apply to change of information applications.

i. Paper Submissions

A signed certification statement shall accompany the paper CMS-855I application. If the provider submits an invalid certification statement or fails to submit a certification statement, the contractor shall still proceed with processing the application. An appropriate certification statement shall be solicited as part of the development process – preferably via email or fax. This includes certification statements that are: (a) unsigned; (b) undated; (c) was signed (as reflected by the date of signature) more than 120 days prior to the date on which the contractor received the application); (d) for paper Form CMS-855I submissions, someone other than the physician or non-physician practitioner signed the form, except as noted in section 10.3.1(C)(1)(h); (e) missing certification statements, or (f) stamped. The contractor shall send one development request to include a list of all of the missing required data/documentation, including the certification statement. The contractor may reject the provider’s application if the provider fails to furnish the missing information on the enrollment application - including all necessary documentation - within 30 calendar days from the date the contractor requested the missing information or documentation. Unless stated otherwise in this chapter or in another CMS directive:

- The contractor shall begin processing the application upon receipt and shall develop for missing certification statements and all other missing information, including application fee, upon review.
- The certification statement may be returned via scanned email or fax.
- Signature dates cannot be prior to 120 days of the receipt date of the application.
- For paper applications that require development, it is only necessary that the dated signature of at least one of the provider’s authorized or delegated officials be on the certification statement that must be sent in within 30 days; obtaining the signatures of the other authorized and delegated officials is not required.
- For paper changes of information applications (as the term “changes of information” is defined in section 10.4(J) of this chapter), if the certification statement is signed by an individual who is not on file with the contractor as being an authorized or delegated official of the provider, the contractor may accept the certification statement but shall develop for information on the person in question in accordance with section 10.3.1(C)(1)(h) of this chapter.
- The contractor is not required to compare the signature thereon with the same provider, authorized or delegated official’s signature on file to ensure that it is the same person. The contractor shall not request the submission of a driver’s license or passport to verify a signature.

ii. Internet-Based PECOS Submissions

If the provider submits its application online and chooses to submit its certification statement via paper rather than through e-signature, it shall do so via

PECOS upload functionality. The provider shall not mail in its paper certification statement as it will not be accepted. Unless stated otherwise in this chapter or in another CMS directive:

- The contractor shall begin processing the application upon receipt and shall develop for missing certification statements and all other missing information, including application fee, upon review.
- Signature dates cannot be prior to 120 days of the receipt date of the application.
- If the provider submits an invalid certification statement, the contractor shall treat this as missing information and develop for a correct certification statement – preferably via email or fax. This includes certification statements that are: (a) unsigned; (b) undated; (c) was signed (as reflected by the date of signature) more than 120 days prior to the date on which the contractor received the application); (d) for paper Form CMS-855I submissions, someone other than the physician or non-physician practitioner signed the form, except as noted in section 10.3.1(C)(1)(h); (e) missing certification statements, or (f) stamped. The contractor shall send one development request to include a list of all of the missing required data/documentation, including the certification statement. The contractor may reject the provider’s application if the provider fails to furnish the missing 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 Internet-based PECOS applications that require development, it is only necessary that the dated signature of at least one of the provider’s authorized or delegated officials be on the certification statement that must be sent in within 30 days; obtaining the signatures of the other authorized and delegated officials is not required.
- For Internet-based PECOS changes of information applications (as the term “changes of information” is defined in section 10.4(J) of this chapter), if the certification statement is signed by an individual who is not on file with the contractor as being an authorized or delegated official of the provider, the contractor may accept the certification statement but shall develop for information on the person in question in accordance with section 10.3.1(C)(1)(h) of this chapter.
- The contractor is not required to compare the signature thereon with the same provider, authorized or delegated official’s signature on file to ensure that it is the same person. The contractor shall not request the submission of a driver’s license or passport to verify a signature.

iii. Certification Statement Development

If the provider submits an invalid certification statement (e.g., unsigned; undated; or stamped signature; signed more than 120 days of the receipt date, incorrect individual signed it; not all authorized officials signed it) or neglects to send a

certification statement, the contractor shall treat this as missing information and develop for a correct certification statement using the procedures outlined in this chapter. The contractor shall send a development letter to the provider – preferably via email or fax.

Any development requests that require the submission of a newly signed certification statement may be submitted for paper applications via scanned email, fax, or mail; and for web applications by upload, fax, email or e-signature. Only the actual signature page is required; the additional page containing the certification terms need not be submitted. This also applies to the provider's initial submission of a certification statement; such instances require the submission of only the signature page and not the certification terms.

k. Medicare Supplier Enrollment Application Privacy Statement

All information collected on form CMS-855I shall be entered into the Provider Enrollment, Chain and Ownership System (PECOS). The Privacy Act permits CMS to disclose information without an individual's consent if the information is to be used for a purpose that is compatible with the purpose(s) for which the information was collected. Any such disclosure of data is known as a "routine use." The CMS will only release PECOS information that can be associated with an individual as provided for under Section III "Proposed Routine Use Disclosures of Data in the System." Both identifiable and non-identifiable data may be disclosed under a routine use. CMS will only collect the minimum personal data necessary to achieve the purpose of PECOS. To view the routine uses in their entirety go to: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/Privacy/Downloads/0532-PECOS.pdf>.

2. Additional Processing Information and Alternatives

a. Unsolicited Additional Information

Regarding unsolicited additional information, if the provider submits missing/clarifying data or documentation on its own volition (i.e., without being contacted by the contractor), the contractor shall include this additional data/documentation in its overall application review. Any new or changed information that a provider submits prior to the date the contractor finishes processing a previously submitted change request is no longer considered to be an update to that change request. Rather, it is considered to be and shall be processed as a separate change request. The contractor may process both changes simultaneously, but the change that was submitted first shall be processed to completion prior to the second one being processed to completion.

b. Information Disclosed Elsewhere

If a data element on the supplier's Form CMS-855I application is missing but the information is disclosed: (1) elsewhere on the application or (2) in the supporting documentation submitted with the application, the contractor need not obtain the missing data via an updated Form CMS-855I page and a newly-signed certification statement; no further development – not even by telephone – is required. The following information, however, must be furnished in the appropriate section(s) of the Form CMS-855I, even if the data is identified elsewhere on the form or in the supporting documentation:

- Any final adverse action data requested in sections 3, 4A, and 6B of the Form CMS-855I
- Legal business names (LBN) or legal names
Note: If an application is submitted with a valid NPI and PTAN combination, but the LBN field is blank, an incomplete or inaccurate LBN is submitted, or the applicant includes a DBA name in the Business Information section of the Form CMS-855I and the contractor is able to confirm the correct LBN based on the NPI and PTAN combination provided, the contractor is not required to develop. (This also applies to Employer's Name for PA's in the Personal Identifying Information (PA Information) section of the Form CMS-855I)
- Tax identification numbers (TIN)
- NPI-legacy number combinations in the Business Information of the Form CMS-855I
Note: MACs may use the shared systems, PECOS or their provider files as a resource to determine the PTAN or NPI before developing to the provider
- Practitioner type in the Personal Identifying Information section of the Form CMS-855I

If the supporting documentation currently exists in the provider's file, the provider or supplier is not required to submit that documentation again during the enrollment process. The MAC shall utilize the existing documentation for verification. Documentation submitted with a previously submitted enrollment application, or documentation currently uploaded in PECOS, qualifies as a processing alternative, unless stated otherwise in this chapter or any CMS directive. Also, per section 10.6.19(H) of this chapter, the contractor shall document in the provider file that the missing information was found elsewhere in the enrollment package. This excludes information that must be verified at the current point in time (i.e. a license without a primary source verification method). Additionally, contractors shall not utilize information submitted along with opt-out applications for enrollment application processing or vice-versa.

c. Licenses

In situations where the supplier is required to submit a copy of a particular professional or business license, certification, registration, or degree but fails to do so, the contractor need not obtain such documentation from the provider if the contractor can verify the information independently. This may be done by: (1) reviewing and printing confirming pages from the applicable state, professional, or school Web site, (2) requesting and receiving from the appropriate state, professional, or educational body written confirmation of the supplier's status therewith, or (3) utilizing another third-party verification source. Similarly, if the provider submits a copy of the applicable license, certification, registration or degree but fails to complete the applicable section of the form, the section need not be completed if the data in question can be verified on the license/certification itself or via any of the three mechanisms described above.

- The above-referenced written confirmation of the supplier's status can be in the form of a letter, fax, or e-mail, but it must be in writing. Documentation of a verbal conversation between the contractor and the body in question does not qualify as appropriate confirmation.

- This exception only applies to those documents that traditionally fall within the category of licenses, registrations, certifications, or degrees. It does not apply to items such as adverse action documentation, paramedic intercept services documents, etc. Furthermore, the exception is moot in cases where: (1) a particular license/certification is not required by the state, or (2) the license/certification has not been obtained because a state survey has not yet been performed (i.e., for certified suppliers).

d. Drug Enforcement Agency (DEA)

DEA certificates are not required. If the applicable DEA certificate is not furnished or the applicable Form CMS-855 section is blank, no further development is needed.

e. City, State, and ZIP Code

If an address (e.g., correspondence address, practice location) lacks a city, state or zip + four, the contractor can verify the missing data in any manner it chooses. In addition, the contractor can obtain the zip + four from either the U.S. Postal Service or the Delivery Point Validation in PECOS.

f. Inapplicable Questions

The supplier need not check “no” for questions that obviously do not apply to its supplier type. For instance, a nurse practitioner need not complete the Personal Identifying Information (Resident Information) section of the Form CMS-855I.

g. Additional Information

- If blank, “Type of Other Name” and “Gender” can be captured orally.
- If the contractor is aware that a particular state does not require licensure/certification and the “Not Applicable” boxes are not checked in the Personal Identifying Information section, no further development is needed.
- In the Personal Identifying Information (Physician Specialty) section, if the supplier uses a checkmark, an “X,” or other symbol to identify his/her primary and secondary specialties (as opposed to a “P” or “S”), no additional development is needed.
- When processing a non-physician practitioner’s (NPP) application, the contractor need not automatically request a copy of the NPP’s degree or diploma (if it is not submitted) if his or her education can be verified through other authorized means; requesting a copy of the degree or diploma should only be done if educational information cannot otherwise be verified.
- Medical or Professional School and Year of Graduation – If the Form CMS-855 lacks the Medical or Professional School and/or the year of graduation, but the information is disclosed in the supporting documentation submitted with the application or already exists in PECOS, no further development is needed.

3. Processing an 855I Ownership Change of Information Application

When a sole owner practitioner has sold his group to another individual practitioner, and the EIN remains unchanged, the contractor shall:

- Process the transaction as a change of information via Form CMS-855I, to change the owner of the group. The contractor shall:
 - Verify the EIN is solely owned by the new owner.
 - Make no change to the PTAN or effective date.
- If applicable, the contractor shall require the prior sole owner individual to submit a voluntary termination application to terminate their individual enrollment/reassignment.

D. CMS-855R - Medicare Enrollment Application for Reassignment of Medicare Benefits

An individual who renders Medicare Part B services and seeks to reassign his or her benefits to an eligible entity should complete this form for each entity eligible to receive reassigned benefits. The individual must be enrolled in the Medicare program as an individual prior to reassigning his or her benefits.

A Form CMS-855R application must be completed for any individual who will: (1) reassign his/her benefits to an eligible entity, (2) terminate an existing reassignment, or (3) designate or change a primary and/or secondary practice location.

The Form CMS-855R application shall not be used to:

- Report employment arrangements of physician assistants (PA); employment arrangements for PAs must be reported on the Form CMS-855I.
- Revalidate reassignments; the individual practitioner should only use the Form CMS-855I application for revalidations and list his/her active reassignment information in the Business Information/Practice Location Information section thereof.
- To view the CMS-855R Processing Guide, go to: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019033.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending>

The guide at the above link constitutes a general Form CMS-855R processing guide for providers/suppliers and contractors. The procedures described in the Guide, which include processing alternatives and processing instructions for the Form CMS-855R, take precedence over all other instructions in this chapter concerning the processing of Form CMS-855R applications.

1. Sections of the CMS-855R

a. Basic Information (Section 1)

In this section, the provider or supplier indicates the reason for submittal of the application. Unless otherwise stated in this chapter or in another CMS directive, the provider may only check one reason for submittal.

Regarding termination of a reassignment, submission of a Form CMS-855R is required to terminate a reassignment. A termination of reassignment cannot be done via the Form CMS-855I (except for Internet-based PECOS applications when the termination is for the last PTAN on an enrollment). The effective date of termination as indicated on the 855R is the day after the effective date of termination. Payment will no longer be made to the organization or group to which benefits are reassigned the day after the effective date of termination.

In situations where the provider or supplier is both adding and terminating a reassignment, each transaction must be reported on a separate Form CMS-855R. The same Form CMS-855R cannot be used for both transactions.

When approving a Form CMS-855R to terminate a reassignment, the contractor shall enter an effective date of termination in PECOS as the day after the day listed on the application. For example: a physician submits a CMS-855R to terminate a reassignment to a group and lists June 30, 2019 as the date of termination. The effective date of the termination listed in PECOS and any correspondence to the provider should be July 1, 2019.

b. Organization/Group Receiving the Reassigned Benefits (Section 2)

i. General Eligibility

Consistent with 42 CFR §424.80(b)(1) and (b)(2) and Pub. 100-04, Chapter 1, sections 30.2.1(D) and (E) and 30.2.6 and 30.2.7 - Medicare may pay: (1) a physician or other provider or supplier's employer if the provider or supplier is required, as a condition of employment, to turn over to the employer the fees for his or her services; or (2) an entity (i.e., a person, group, or facility) that is enrolled in the Medicare program for services furnished by a physician or other provider or supplier under a contractual arrangement with that entity. This means that Part A and Part B entities other than physician/practitioner group practices can receive reassigned benefits, assuming the requirements for a reassignment exception are met.

Per Pub. 100-04, chapter 1, section 30.2.7, a contractor may permit a reassignment of benefits to any eligible entity regardless of where the service was rendered or whether the entity owned or leased that location. As such, the contractor need not verify the entity's ownership or leasing arrangement with respect to the reassignment.

A. Organizational/Group Receiving the Reassigned Benefits

An organization or clinic/group practice can receive reassigned benefits. The most common example of this is a physician or practitioner who reassigns his/her benefits to a physician group who is either that has enrolled via the CMS-855B. Here, the only forms that are necessary are the Form CMS-855R and separate Form CMS-855Is from the reassignor and a CMS-855B for the reassignee. The reassignee's Authorized or Delegated Official must sign the Certification Statements and Signatures section of the Form CMS-855R, along with the reassignor.

B. Individual Practitioner Identification

An individual can receive reassigned benefits. The most common example of this is a physician or practitioner who reassigns his/her benefits to a physician who is either (1) a sole proprietor, or (2) the sole owner of an entity listed in the Business Information

section of the Form CMS-855I. Here, the only forms that are necessary are the Form CMS-855R and separate Form CMS-855Is from the reassignor and the reassignee. (No Form CMS-855B or Form CMS-855A is involved.) The reassignee himself/herself must sign the Certification Statements and Signatures section of the Form CMS-855R, as there is no authorized or delegated official involved.

The contractor shall follow the instructions in Pub. 100-04, Chapter 1, sections 30.2 – 30.2.16 to ensure that a physician or other provider or supplier is eligible to receive reassigned benefits.

Regarding reassignment and revoked or deceased physicians, refer to 10.6.17(G)(1).

ii. Inter-Jurisdictional Reassignments

If a physician/NPP (reassignor) is reassigning his or her benefits to an entity (reassignee) located in another contractor jurisdiction – a practice that is permissible - principles in the following sections apply.

A. Inter-Jurisdictional Reassignments: General Policy

- The reassignor must be properly licensed or otherwise authorized to perform services in the state in which he or she has his or her practice location. The practice location can be an office or even the individual's home (for example, a physician interprets test results in his home for an independent diagnostic testing facility).
- The reassignor need not – pursuant to the reassignment - enroll in the reassignee's contractor jurisdiction nor be licensed/authorized to practice in the reassignee's state. If the reassignor will be performing services within the reassignee's state, the reassignor must enroll with the Medicare contractor for – and be licensed/authorized to practice in – that state.
- The reassignee must enroll in the contractor jurisdictions in which (1) it has its own practice location(s), and (2) the reassignor has his or her practice location(s). In Case (2), the reassignee:
 - Shall identify the reassignor's practice location as its practice location on its Form CMS-855B
 - In the Practice Location Information of its Form CMS-855B shall select the practice location type as "Other health care facility" and specify "Telemedicine location."
 - Need not be licensed/authorized to perform services in the reassignor's state.

To illustrate, suppose Dr. Smith is located in Contractor Jurisdiction X and is reassigning his benefits to Jones Medical Group in Contractor Jurisdiction Y. Jones must enroll with X and with Y. Jones need not be licensed/authorized to perform services in Dr. Smith's state. However, in the Practice Location Information section of the Form CMS- 855B it submits to X, Jones must list Dr. Smith's location as its practice location.

B. Inter-Jurisdictional Reassignments: Applicability

The term "reassignee," as used in section 10.3.1(D)(1)(b), includes any provider or supplier that is permitted to bill and receive payment under a reassignment, in accordance with existing Medicare policy.

iii. Reassignment to CAHs

Reassignment to a Part A provider or supplier might occur when (1) a physician or other provider or supplier reassigning benefits to a hospital, skilled nursing facility, or critical access hospital billing under Method II (CAH II) or (2) a nurse practitioner reassigning to a CAH II.

If the entity receiving the reassigned benefits is not a CAH II, it must enroll with the contractor via a Form CMS-855B, and the physician/practitioner reassigning benefits must complete and submit a Form CMS-855I and Form CMS-855R.

If the entity receiving the reassigned benefits is a CAH II, the entity need not and should not complete a separate Form CMS-855B form to receive reassigned benefits. The physician/practitioner can reassign benefits directly to the CAH II's, Part A enrollment. The distinction between CAHs billing Method I vs. Method II only applies to outpatient services; it does not apply to inpatient services.

Under Method I:

- The CAH bills for facility services
- The physicians/practitioners bill separately for their professional services

Under Method II:

- The CAH bills for facility services
- If a physician/practitioner has reassigned his/her benefits to the CAH, the CAH bills for that particular physician's/practitioner's professional service
- If a CAH has elected Method II, the physician/practitioner is not required to reassign his or her benefits to the CAH. For those physicians/practitioners who do not reassign their benefits to the CAH, the CAH only bills for facility services and the physicians/practitioners separately bill for their professional services (similar to Method I).

Although physicians or non-physician practitioners are not required to reassign their benefits to a CAH that bills Method II, doing so allows them to participate in the Electronic Health Records (EHR) Incentive Program for Eligible Professionals (EPs).

In this scenario the CMS-855I and CMS-855R shall be submitted to the Part B MAC and the CMS-855A submitted to the Part A MAC. The Part B MAC shall be responsible for reassigning the individual to the Part A entity.

The reassignment to the Part A entity shall only occur if the CMS-855A for the CAH II has been finalized. This can be determined by viewing PECOS to identify if an approved enrollment exists for the CAH II. If one does not, the Part B MAC shall return the CMS-855I and/or CMS-855R to the provider. If an enrollment record exist but is in an Approved Pending RO Review status, the Part B MAC shall contact the Part A MAC to determine if the Tie-In has been received from the RO but not yet updated in PECOS, prior to returning the applications.

c. Individual Practitioner Who is Reassigning Benefits (Section 3)

If the individual who wants to reassign his or her benefits is not enrolled in Medicare, the person must complete a Form CMS-855I as well as a Form CMS-855R. (The CMS-855I and CMS-855R can be submitted concurrently.) Moreover, if the entity to which the person's benefits will be reassigned is not enrolled in Medicare, the organization must complete a Form CMS-855B or, if applicable, a Form CMS-855A. (See section 10.4(B)(3) for additional instructions regarding the joint processing of Form CMS-855As, Form CMS-855Rs, Form CMS-855Bs, and Form CMS-855Is.)

Benefits are reassigned to a provider or supplier, not to the practice location(s) of the provider or supplier. As such, the contractor shall not require each practitioner in a group to submit a Form CMS-855R each time the group adds a practice location.

The contractor need not verify whether the reassigning individual is a W-2 employee or a 1099 contractor.

Regarding reassignment and revoked or deceased physicians, refer to 10.6.17(G)(1).

d. Primary Practice Location(s) (Section 4)

The location(s) of the organization/group that the individual practitioner will render services most of the time. The location(s) listed in this section must be currently enrolled or enrolling in Medicare.

e. Contact Person Information (Section 5)

Regarding the optional contact person information in the Contact Person section of the Form CMS-855R, refer to Section 10.6.9 (of this chapter) regarding Contact Persons:

- If this section is completely blank, the contractor need not develop for this information and can simply contact the party that submitted the form (e.g., the enrolling physician).
- If a contact person is listed, any other missing data (e.g., address, e-mail) can be captured via telephone.

f. Certification Statements and Signatures (Section 6)

The provider may submit their certification statement via e-signature or paper to their contractor.

If an individual is initiating a reassignment, both he/she and the group's authorized or delegated official must sign The Certification Statements and Signatures section of the Form CMS-855R. If either of the two signatures is missing, the contractor shall develop for it.

If an individual (or group) is terminating a reassignment, either party may sign the Certification Statements and Signatures section of the Form CMS-855R; obtaining both signatures is not required. If no signatures are present, the contractor shall develop for a signature.

The authorized or delegated official who signs the Certification Statements and Signatures section of the Form CMS-855R must be currently on file with the contractor as such. If this is a new enrollment - with a joint submission of the Form(s) CMS-855A or CMS 855B, Form CMS-855I, and Form CMS-855R, the person must be listed on the CMS-855A or CMS-855B as an authorized or delegated official.

There may be situations where a Form CMS-855R is submitted and the reassignee is already enrolled in Medicare via the Form CMS-855B. However, the authorized official is not on file. In this case, the contractor shall develop for a Form(s) CMS-855A or CMS-855B change request that adds the new authorized official.

For Form CMS-855R initial applications, the certification statement must be signed and dated by the physician or non-physician practitioner and the authorized official or delegated official of the provider or supplier. This applies to: (1) signatures on the paper Form CMS-855, (2) signatures on the certification statement for Internet-based Provider Enrollment, and electronic signatures.

For Form CMS-855R applications submitted to change and/or update the provider or supplier's Medicare enrollment data, to include updates to the primary practice location or termination of a reassignment, the certification statement may be signed by either the physician or non-physician practitioner or the authorized or delegated official of the provider or supplier. This applies to: (1) signatures on the paper Form CMS-855R, (2) signatures on the certification statement for Internet-based Provider Enrollment, and electronic signatures.

Valid signatures include handwritten (wet) signatures in ink and digital/electronic signatures (digital or electronic signatures such as those created by digital signature options, created in software, such as Adobe) shall be accepted. Contractors shall contact their PEOG BFL for questions regarding electronic signatures.

All signatures (handwritten or digital) are valid and appropriate in regards to (1) signatures on the paper Form CMS-855R (2) uploaded signatures on the certification statement for Internet-based Provider Enrollment, Chain and Ownership System (PECOS) applications.

i. Paper Submissions

A signed certification statement shall accompany the paper CMS-855R application. If the provider submits an invalid certification statement or fails to submit a certification statement, the contractor shall still proceed with processing the application. An appropriate certification statement shall be solicited as part of the development process – preferably via email or fax. This includes certification statements that are: (a) unsigned; (b) undated; (c) was signed (as reflected by the date of signature) more than 120 days prior to the date on which the contractor received the application); (d) missing certification statements, or (e) stamped. The contractor shall send one development request to include a list of all of the missing required data/documentation, including the certification statement. The

contractor may reject the provider's application if the provider fails to furnish the missing information on the enrollment application - including all necessary documentation - within 30 calendar days from the date the contractor requested the missing information or documentation. Unless stated otherwise in this chapter or in another CMS directive:

- The contractor shall begin processing the application upon receipt and shall develop for missing certification statements and all other missing information, including application fee, upon review.
- The certification statement may be returned via scanned email or fax.
- Signature dates cannot be prior to 120 days of the receipt date of the application.
- For paper applications that require development, it is only necessary that the dated signature of at least one of the provider's authorized or delegated officials be on the certification statement that must be sent in within 30 days; obtaining the signatures of the other authorized and delegated officials is not required.
- For paper changes of information applications (as the term "changes of information" is defined in section 10.4(J) of this chapter), if the certification statement is signed by an individual who is not on file with the contractor as being an authorized or delegated official of the provider, the contractor may accept the certification statement but shall develop for information on the person in question in accordance with section 10.3.1(D)(1)(f) this chapter.
- The contractor is not required to compare the signature thereon with the same provider, authorized or delegated official's signature on file to ensure that it is the same person. The contractor shall not request the submission of a driver's license or passport to verify a signature.

ii. Internet-Based PECOS Submissions

If the provider submits its application online and chooses to submit its certification statement via paper rather than through e-signature, it shall do so via PECOS upload functionality. The provider shall not mail in its paper certification statement as it will not be accepted. Unless stated otherwise in this chapter or in another CMS directive:

- The contractor shall begin processing the application upon receipt and shall develop for missing certification statements and all other missing information, including application fee, upon review.
- Signature dates cannot be prior to 120 days of the receipt date of the application.
- If the provider submits an invalid certification statement, the contractor shall treat this as missing information and develop for a correct certification statement – preferably via email or fax. This includes certification statements that are: (a) unsigned; (b) undated; (c) was signed (as reflected by the date of

signature) more than 120 days prior to the date on which the contractor received the application); (d) missing certification statements, or (e) stamped. The contractor shall send one development request to include a list of all of the missing required data/documentation, including the certification statement. The contractor may reject the provider's application if the provider fails to furnish the missing 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 Internet-based PECOS applications that require development, it is only necessary that the dated signature of at least one of the provider's authorized or delegated officials be on the certification statement that must be sent in within 30 days; obtaining the signatures of the other authorized and delegated officials is not required.
- For Internet-based PECOS changes of information applications (as the term "changes of information" is defined in section 10.4(J) of this chapter), if the certification statement is signed by an individual who is not on file with the contractor as being an authorized or delegated official of the provider, the contractor may accept the certification statement but shall develop for information on the person in question in accordance with section 10.3.1(D)(1)(f) of this chapter.
- The contractor is not required to compare the signature thereon with the same provider, authorized or delegated official's signature on file to ensure that it is the same person. The contractor shall not request the submission of a driver's license or passport to verify a signature.

iii. Certification Statement Development

If the provider submits an invalid certification statement (e.g., unsigned; undated; or stamped signature; signed more than 120 days of the receipt date, incorrect individual signed it; not all authorized officials signed it) or neglects to send a certification statement, the contractor shall treat this as missing information and develop for a correct certification statement using the procedures outlined in this chapter. The contractor shall send a development letter to the provider – preferably via email or fax.

Any development requests that require the submission of a newly signed certification statement may be submitted for paper applications via scanned email, fax, or mail; and for web applications by upload, fax, email or e-signature. Only the actual signature page is required; the additional page containing the certification terms need not be submitted. This also applies to the provider's initial submission of a certification statement; such instances require the submission of only the signature page and not the certification terms.

g. Medicare Supplier Enrollment Application Privacy Statement

All information collected on form CMS-855R shall be entered into the Provider Enrollment, Chain and Ownership System (PECOS). The Privacy Act permits CMS to disclose information without an individual's consent if the information is to be used for a purpose that is compatible with the purpose(s) for which the information was collected. Any such disclosure of data is known as a "routine use." The CMS will only release PECOS

information that can be associated with an individual as provided for under Section III “Proposed Routine Use Disclosures of Data in the System.” Both identifiable and non-identifiable data may be disclosed under a routine use. CMS will only collect the minimum personal data necessary to achieve the purpose of PECOS. To view the routine uses in their entirety go to: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/Privacy/Downloads/0532-PECOS.pdf>.

2. Processing Alternatives

a. Unsolicited Additional Information

Regarding unsolicited additional information, if the provider submits missing/clarifying data or documentation on its own volition (i.e., without being contacted by the contractor), the contractor shall include this additional data/documentation in its overall application review. Any new or changed information that a provider submits prior to the date the contractor finishes processing a previously submitted change request is no longer considered to be an update to that change request. Rather, it is considered to be and shall be processed as a separate change request. The contractor may process both changes simultaneously, but the change that was submitted first shall be processed to completion prior to the second one being processed to completion.

b. Information disclosed elsewhere

Note: If an application is submitted with a valid NPI and PTAN combination, but the LBN field is blank, an incomplete or inaccurate LBN is submitted, or the applicant includes a DBA name in the Organization/Group (or Individual) Receiving the Reassigned Benefits section of the Form CMS-855R and the contractor is able to confirm the correct LBN based on the NPI and PTAN combination provided, the contractor is not required to develop.

MACs may use the shared systems, PECOS or their provider files as a resource to determine the PTAN or NPI of the group/organization/individual that is receiving the reassigned benefits before developing to the provider for existing individual practitioners only. If information is missing from the 855R that cannot be verified in PECOS, the Shared Systems or provider files, then a development would have to be issued (i.e.: group information is missing from the 855R and not included in the 855I Business Information section, this cannot be verified elsewhere).

c. Related Applications: Processing Related CMS-855R and CMS-855I Applications

The MAC shall begin processing new reassignment applications, developing for all signatures and any missing information from the individual practitioner and the authorized/delegated official. This is for both paper and Internet-based PECOS CMS-855R applications.

In situations when a newly enrolling supplier is reassigning benefits, such a supplier would need to submit both the CMS-855I and CMS-855R. When one or both of these two forms requires the contractor to develop for information, the contractor may honor the receipt date of the application that is submitted as complete sooner (i.e. no further development necessary), and apply that date equally to both the CMS-855I and CMS-855R.

d. Related Applications: Processing Related CMS-855R and CMS-855B Applications

In situations when a newly enrolling group is accepting reassignment of benefits from an existing practitioner, such a supplier would need to submit both the CMS-855B and CMS-855R. When one or both of these two forms requires the contractor to develop for information, the contractor may honor the receipt date of the application that is submitted as complete sooner (i.e. no further development necessary), and apply that date equally to both the CMS-855B and CMS-855R.

E. CMS-855O – Medicare Enrollment Application for Eligible Ordering, Certifying Physicians, and other Eligible Professionals

This form is used for physicians and other eligible professionals who wish to register in Medicare solely for the purpose of ordering, and certifying. These physicians and other eligible professionals do not and will not send claims to a MAC for the services they furnish. Further, providers who have opted out of Medicare enrollment are not permitted to enroll via the form 855O for the purposes of ordering, certifying, or prescribing.

1. Sections of the CMS-855O

a. Basic Information (Section 1)

In this section, the ordering, certifying or prescribing individual indicates the reason for submittal of the application. Unless otherwise stated in this chapter or in another CMS directive, the ordering, certifying or prescribing individual may only check one reason for submittal.

With the exception of the voluntary termination checkbox, any blank data/checkboxes in the Basic Information section can be verified through any means chosen by the contractor (e.g., e-mail, telephone, fax).

b. Identifying Information (Section 2)

i. License/Certifications/Registration Information

The extent to which the ordering, certifying or prescribing individual must complete the licensure, certification, or accreditation information depends upon the ordering, certifying or prescribing individual provider type involved. Requirements vary by ordering, certifying or prescribing individual provider type and by location, for instance, some states may require a particular provider type to be “certified” but not “licensed,” or vice versa. In general, individuals complete information regarding licensure (a check box “License Not Applicable” is provided to reflect those instances where a state does not require licensure or in the case of unlicensed residents if the application submission includes either, 1) a Residency Contract signed and dated by both an official of the institution and the Resident Physician or, 2) a letter, on institution letterhead, confirming the applicants status as a Resident Physician signed and dated by an official of the institution and containing at a minimum the name of the applicant).

The only licenses that must be submitted with the application are those required by Medicare or the state to function as the ordering, certifying or prescribing individual type in question. Licenses and permits that are not of a medical nature are not required. In addition, there may be instances where the ordering, certifying or prescribing individual is not required to be licensed at all in a particular state; the contractor shall

still ensure, however, that the supplier meets all applicable state and Medicare requirements.

In situations where the supplier is required to submit a copy of a particular professional or business license, certification, registration, or degree but fails to do so, the contractor need not obtain such documentation from the provider if the contractor can verify the information independently. This may be done by: (1) reviewing and printing confirming pages from the applicable state, professional, or school web site, (2) requesting and receiving from the appropriate state, professional, or educational body written confirmation of the supplier's status therewith, or (3) utilizing another third-party verification source. Likewise, if the provider submits a copy of the applicable license, certification, registration or degree but fails to complete the applicable section of the form, the section need not be completed if the data in question can be verified on the license/certification itself or via any of the three mechanisms above.

ii. Correspondence Address and Telephone Number

Regarding the correspondence address under the Important Address Information section of the Form CMS-855O, 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. The contractor is not required to verify the correspondence address. 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 applicant may list any telephone number it wishes as the correspondence phone number. The number need not link to the listed correspondence address. If the provider fails to list a correspondence telephone number and it is required for the application submission, the contractor shall develop for this information – preferably via email or fax. The contractor shall accept a particular phone number if it has no reason to suspect that it does not belong to or is not somehow associated with the provider. The contractor is not required to verify the telephone number.

iii. 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.

iv. Drug Enforcement Agency (DEA)

DEA certificates need not be submitted if the applicable DEA information was furnished on the CMS-855. Similarly, if the aforementioned certificates are furnished but the applicable CMS-855 sections are blank, no further development is needed.

c. Final Adverse Legal Actions/Convictions (Section 3)

Refer to Section 10.6.6 of this chapter for information regarding final adverse actions.

d. Medical Specialty Information (Section 4)

The contractor shall validate that any provider identifying a primary specialty on the CMS-855O application has the appropriate medical license. The contractor shall validate the license using the state's medical license website. If an active license is not found, the contractor shall develop via telephone, fax, email, or mail to confirm the provider's intent and to obtain a copy of the license, if applicable.

e. Important Address Information (Section 5)

The address information provided in the Important Address Information section of the Form CMS-855O provides the MAC with the ability to contact you directly, if necessary.

f. Contact Person Information (Section 6)

Regarding the option to list contact person information in the Contact Persons section of the Form CMS-855O, refer to Section 10.6.9 (of this chapter) regarding Contact Persons. If this section is completely blank, the contractor need not develop for this information and can simply contact the physician or practitioner.

Currently there is no option on the CMS-855O form to delete a contact person. Therefore, contractors shall accept end dates of a contact person via phone, email, fax or mail from the individual provider, or a current contact person on file. Contractors shall document in the comment section in PECOS who requested the termination, how it was requested (email, phone or fax) and when it was requested. The addition of contact persons must still be reported via the appropriate CMS-855O form.

g. Penalties for Falsifying Information (Section 7)

Please refer to Penalties for Falsifying Information section of the Form CMS-855O for an explanation of penalties that apply to providers and suppliers for deliberately furnishing false information in this application to gain or maintain enrollment in the Medicare program.

h. Certification Statement (Section 8)

The provider may submit their certification statement via e-signature, web upload or paper to their contractor.

The enrolling or enrolled physician or other eligible professional is the only person who can sign the Form CMS-855O. (This applies to initial enrollments, changes of information, reactivations, voluntary withdrawals, etc.) A physician or other eligible professional may not delegate the authority to sign the Form CMS-855O on his/her behalf to any other person. This applies to: (1) signatures on the paper Form CMS-855O, (2) signatures on the certification statement for Internet-based Provider Enrollment, and electronic signatures.

Valid signatures include handwritten (wet) signatures in ink and digital/ signatures (digital or electronic signatures such as those created by digital signature options, created in software, such as Adobe) shall be accepted. Contractors shall contact their PEOG BFL for questions regarding electronic signatures.

All signatures (handwritten or digital) are valid and appropriate in regards to (1) signatures on the paper Form CMS-855O (2) uploaded signatures on the certification statement for Internet-based Provider Enrollment, Chain and Ownership System (PECOS) applications.

Note: In the case of death, an executor of the estate, may sign on behalf of the deceased provider. This situation would only apply to change of information applications.

i. Paper Submissions

A signed certification statement shall accompany the paper CMS-855O application. If the provider submits an invalid certification statement or fails to submit a certification statement, the contractor shall still proceed with processing the application. An appropriate certification statement shall be solicited as part of the development process – preferably via email or fax. This includes certification statements that are: (a) unsigned; (b) undated; (c) was signed (as reflected by the date of signature) more than 120 days prior to the date on which the contractor received the application); (d) for paper Form CMS-855O submissions, someone other than the physician or non-physician practitioner signed the form, except as noted in section 10.3.1(E)(1)(h); (e) missing certification statements, or (f) stamped. The contractor shall send one development request to include a list of all of the missing required data/documentation, including the certification statement. The contractor may reject the provider's application if the provider fails to furnish the missing information on the enrollment application - including all necessary documentation - within 30 calendar days from the date the contractor requested the missing information or documentation. Unless stated otherwise in this chapter or in another CMS directive:

- The contractor shall begin processing the application upon receipt and shall develop for missing certification statements and all other missing information.
- The certification statement may be returned via scanned email or fax.
- Signature dates cannot be prior to 120 days of the receipt date of the application.
- For paper applications that require development, it is necessary that the provider's dated signature be on the certification statement that must be sent in within 30 days.
- For paper changes of information applications (as the term "changes of information" is defined in section 10.4(J) of this chapter), the contractor shall only accept a certification statement signed by the individual physician or practitioner.
- The contractor is not required to compare the signature thereon with the same provider's signature on file to ensure that it is the same person. The contractor shall not request the submission of a driver's license or passport to verify a signature.

ii. Internet-Based PECOS Submission

If the provider submits its application online and chooses to submit its certification statement via paper rather than through e-signature, it shall do so via PECOS upload functionality. The provider shall not mail in its paper certification

statement as it will not be accepted. Unless stated otherwise in this chapter or in another CMS directive:

- The contractor shall begin processing the application upon receipt and shall develop for missing certification statements and all other missing information, including application fee, upon review.
- Signature dates cannot be prior to 120 days of the receipt date of the application.
- If the provider submits an invalid certification statement, the contractor shall treat this as missing information and develop for a correct certification statement – preferably via email or fax. This includes certification statements that are: (a) unsigned; (b) undated; (c) was signed (as reflected by the date of signature) more than 120 days prior to the date on which the contractor received the application); (d) for paper Form CMS-855O submissions, someone other than the physician or non-physician practitioner signed the form, except as noted in section 10.3.1(E)(1)(h); (e) missing certification statements, or (f) stamped. The contractor shall send one development request to include a list of all of the missing required data/documentation, including the certification statement. The contractor may reject the provider’s application if the provider fails to furnish the missing 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 Internet-based PECOS applications that require development, it is necessary that the provider’s dated signature be on the certification statement that must be sent in within 30 days.
- For Internet-based PECOS changes of information applications (as the term “changes of information” is defined in section 10.4(J) of this chapter), the contractor shall only accept a certification statement signed by the individual physician or practitioner.
- The contractor is not required to compare the signature thereon with the same provider, authorized or delegated official’s signature on file to ensure that it is the same person. The contractor shall not request the submission of a driver’s license or passport to verify a signature.

iii. Certification Statement Development

If the provider submits an invalid certification statement (e.g., unsigned; undated; or stamped signature; signed more than 120 days of the receipt date, incorrect individual signed it; not all authorized officials signed it) or neglects to send a certification statement, the contractor shall treat this as missing information and develop for a correct certification statement using the procedures outlined in this chapter. The contractor shall send a development letter to the provider – preferably via email or fax.

Any development requests that require the submission of a newly signed certification statement may be submitted for paper applications via scanned email, fax, or mail; and for web applications by upload, fax, email or e-signature. Only the actual signature page is required; the additional page containing the certification terms need not be submitted. This also applies to the provider's initial submission of a certification statement; such instances require the submission of only the signature page and not the certification terms.

i. Medicare Supplier Enrollment Application Privacy Statement

All information collected on form CMS-855O shall be entered into the Provider Enrollment, Chain and Ownership System (PECOS). The Privacy Act permits CMS to disclose information without an individual's consent if the information is to be used for a purpose that is compatible with the purpose(s) for which the information was collected. Any such disclosure of data is known as a "routine use." The CMS will only release PECOS information that can be associated with an individual as provided for under Section III "Proposed Routine Use Disclosures of Data in the System." Both identifiable and non-identifiable data may be disclosed under a routine use. CMS will only collect the minimum personal data necessary to achieve the purpose of PECOS. To view the routine uses in their entirety go to: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/Privacy/Downloads/0532-PECOS.pdf>.

2. Additional Processing Information and Alternatives for Form CMS-855O

a. Unsolicited Additional Information

Regarding unsolicited additional information, if the provider submits missing/clarifying data or documentation on its own volition (i.e., without being contacted by the contractor), the contractor shall include this additional data/documentation in its overall application review. Any new or changed information that a provider submits prior to the date the contractor finishes processing a previously submitted change request is no longer considered to be an update to that change request. Rather, it is considered to be and shall be processed as a separate change request. The contractor may process both changes simultaneously, but the change that was submitted first shall be processed to completion prior to the second one being processed to completion.

b. General Processing Alternatives

The following general alternatives are applicable to all sections of the Form CMS-855O, unless otherwise specified:

- If blank, "Type of Other Name" and "Gender" can be captured orally.
- If the contractor is aware that a particular state does not require licensure/certification and the "Not Applicable" boxes are not checked in the Personal Identifying Information (License/ Certification/ Registration Information) section, no further development is needed.
- When processing a non-physician practitioner's (NPP) application, the contractor need not automatically request a copy of the NPP's degree or diploma (if it is not submitted) if his or her education can be verified through other authorized means;

requesting a copy of the degree or diploma should only be done if educational information cannot otherwise be verified.

c. Information Disclosed Elsewhere

If a data element on the supplier's Form CMS-855O application is missing but the information is disclosed (1) elsewhere on the application or (2) in the supporting documentation submitted with the application, the contractor need not obtain the missing data via an updated Form CMS-855O page and a newly-signed certification statement; no further development – not even by telephone – is required. The following information, however, must be furnished in the appropriate section(s) of the Form CMS-855O, even if the data is identified elsewhere on the form or in the supporting documentation:

- Any final adverse action data requested in the Final Adverse Legal Actions section
- Legal names
- Tax identification number (TIN)
- NPI-legacy number combinations in the Identifying Information section (if applicable) Note: MACs may use the shared systems, PECOS or their provider files as a resource to determine the PTAN or NPI before developing to the provider.
- Data in the Basic Information section

If the supporting documentation currently exists in the provider's file, the provider or supplier is not required to submit that documentation again during the enrollment process. The MAC shall utilize the existing documentation for verification. Documentation submitted with a previously submitted enrollment application, or documentation currently uploaded in PECOS, qualifies as a processing alternative, unless stated otherwise in this chapter or any CMS directive. Also, per section 10.6.19(H) of this chapter, the contractor shall document in the provider file that the missing information was found elsewhere in the enrollment package. This excludes information that must be verified at the current point in time (i.e. a license without a primary source verification method). Additionally, contractors shall not utilize information submitted along with opt-out applications for enrollment application processing or vice-versa.

d. City, State, and ZIP Code

If a particular address lacks a city or state, the contractor can verify the missing data in any manner it chooses. In addition, the contractor can obtain the zip + four from either the U.S. Postal Service or Delivery Point Validation in PECOS.

e. Sectional Processing Alternatives

The processing alternatives in this subsection 10.3.1(E)(2) are in addition to, and not in lieu of, those in subsection 10.3.1(E)(1).

f. Processing Initial Form CMS-855O Submissions

The instructions in sections 10.4 through 10.4(F) of this chapter take precedence over those in sections 10.3.1(E)(2)(f).

i. Receipt

Upon receipt of an initial Form CMS-855O the contractor may begin the verification process at any time. Also, the contractor is not required to create a PECOS logging and tracking (L & T) record within a certain specified timeframe (e.g., within 20 days after receipt of the application).

NOTE: The physician/other eligible professional need not submit a Form CMS-460, a Form CMS-588, or an application fee with his or her Form CMS-855O.

Section 10.4(H)1 of this chapter outlines the reasons for which the contractor may immediately return a Form CMS-855O. If the contractor determines that one or more of these reasons applies, it may return the form in accordance with the instructions outlined in that section.

ii. Verification

Unless stated otherwise in this chapter or in another CMS directive, the contractor shall verify all of the information on the Form CMS-855O. This includes, but is not limited to:

- Verification of the individual's name, date of birth, social security number, and National Provider Identifier (NPI).
- Verification that the individual meets the requirements for his/her supplier type. (The contractor reserves the right to request that the individual submit documentation verifying his or her professional licensure, credentials, or education.)
- Verification that the individual is of a supplier type that can legally order or certify.
- Reviewing the Medicare Exclusion Database (MED) and System for Award Management (SAM) to ensure that the individual is not excluded or debarred.

If, at any time during the verification process, the contractor needs additional or clarifying information from the physician/other eligible professional, it shall follow existing CMS instructions for obtaining said data (e.g., sending a developmental letter). The information must be furnished to the contractor within 30 calendar days of the contractor's request.

iii. Disposition

Upon completion of its review of the form, the contractor shall approve, deny, or reject it.

Grounds for denial are as follows:

- The supplier is not of a type that is eligible to use the Form CMS-855O.

- The supplier is not of a type that is eligible to order or certify items or services for Medicare beneficiaries.
- The supplier does not meet the licensure, certification or educational requirements for his or her supplier type.
- The supplier is excluded per the MED and/or debarred per the SAM.

If the contractor believes that another ground for denial exists for a particular submission, it should contact its CMS Provider Enrollment Business Function Lead for guidance.

The Form CMS-855O may be rejected if the supplier fails to furnish all required information on the form within 30 calendar days of the contractor's request to do so. (This includes situations in which information was submitted, but could not be verified.) The basis for rejection shall be 42 CFR § 424.525(a).

When denying or rejecting the Form CMS-855O submission, the contractor shall: (1) switch the PECOS record to a "denied" or "rejected" status (as applicable), and (2) send a letter to the supplier notifying him or her of the denial or rejection and the reason(s) for it. The letter shall follow the formats outlined in sections 10.4(H)(2) (rejections) and 10.4(H)(3) (denials) of this chapter. Denial letters shall be sent via certified mail. Rejection letters shall be sent by mail or e-mail. (NOTE: A denial triggers appeal rights. A rejection does not.)

If the Form CMS-855O is approved, the contractor shall: (1) switch the PECOS record to an "approved" status, and (2) send a letter (via mail or e-mail) to the supplier notifying him or her of the approval. The letter shall follow the format outlined in section 10.7.3 of this chapter.

iv. Miscellaneous

NOTE: The contractor shall observe the following:

- The supplier shall be treated as a non-participating supplier (or "non-par").
- If the supplier is employed by the DVA, the DOD, or the IHS, he or she – for purposes of the Form CMS-855O - need only be licensed or certified in one State. Said State need not be the one in which the DVA or DOD office is located.
- Nothing in sections 10.3.1(E)(2)(f)(ii) through 10.3.1 (E)(2)(h) affects any existing CMS instructions regarding the processing of opt-out affidavits.
- Suppliers cannot submit an abbreviated version of the Form CMS-855I in lieu of the Form CMS-855O.
- The effective date of enrollment shall be the date on which the contractor received the paper form or the date a Web-based application is submitted.
- If the supplier's Form CMS-855O has been approved and he or she later wants to obtain Medicare billing privileges, he or she must voluntarily withdraw his or her

Form CMS-855O enrollment prior to receiving Medicare billing privileges. (The supplier, of course, must complete the Form CMS-855I in order to receive Medicare billing privileges.)

g. Processing Form CMS-855O Change of Information Requests

i. Receipt

The contractor may begin the verification process at any time. Also, the contractor is not required to create a PECOS logging and tracking (L & T) record within a certain specified timeframe (e.g., within 20 days after receipt of the application).

Section 10.4(H)(1) of this chapter outlines the reasons for which the contractor may immediately return a Form CMS-855O. If the contractor determines that one or more of these reasons applies, it may return the change request via the instructions outlined in that section.

Suppliers who are enrolled in Medicare via the Form CMS-855I may not report changes to their enrollment information via the Form CMS-855O. They must use the Form CMS-855I. Similarly, suppliers whose Form CMS-855O submissions have been approved must use the Form CMS-855O to report information changes; they cannot use the Form CMS-855I for this purpose.

A. Verification

Unless stated otherwise in this chapter or in another CMS directive, the contractor shall verify the new information that the supplier furnished on the Form CMS-855O. (This includes checking the supplier against the Medicare Exclusion Database and the System for Award Management (SAM).) If, at any time during the verification process, the contractor needs additional or clarifying information, it shall follow existing CMS instructions for obtaining said data (e.g., sending a developmental letter). The information must be furnished to the contractor within 30 calendar days of the contractor's request.

B. Disposition

Upon completion of its review of the change request, the contractor shall approve, deny, or reject the submission. The principal ground for denial will be that the new information was furnished, but could not be verified. If the contractor believes that this is the case or if another ground for denial exists with respect to a particular submission, it should contact its CMS Provider Enrollment & Oversight Group Business Function Lead (PEOG BFL) for guidance.

The change request may be rejected if the supplier failed to furnish all required information on the form within 30 calendar days of the contractor's request to do so. The basis for rejection shall be 42 CFR § 424.525(a).

When denying or rejecting the change request, the contractor shall: (1) switch the PECOS record to a "denied" or "rejected" status (as applicable), and (2) send a letter (via mail or e-mail) to the supplier notifying him or her of the denial or rejection and the reason(s) for it.

If the change request is approved, the contractor shall (1) switch the PECOS record to an “approved” status, and (2) send a letter (via mail or e-mail) to the supplier notifying him or her of the approval.

C. Relocation

Since the CMS-855O is a national enrollment, providers who relocate to another state are not required to dis-enroll in the current state and re-enroll in the new state. The contractor that maintains the CMS-855O enrollment in PECOS is responsible for processing the change of information, even if the provider is relocating to a state outside of their jurisdiction. If any new licenses and/or certifications are obtained as a result of the provider’s relocation, the contractor shall ensure that the updated information is captured in the provider’s enrollment record.

This policy applies to any physician, non-physician practitioner or resident that is enrolled via the CMS-855O application.

h. Form CMS-855O Revocations

If the contractor determines that grounds exist for revoking the supplier’s Form CMS-855O enrollment, it shall:

- Switch the supplier’s Provider Enrollment, Chain and Ownership System (PECOS) record to a “revoked” status,
- End-date the PECOS record, and
- Send a letter via certified mail to the supplier stating that his or her Form CMS-855O enrollment has been revoked. The letter shall follow the format outlined in section 10.7.8 of this chapter.

Grounds for revoking the supplier’s Form CMS-855O enrollment are as follows:

- The supplier is no longer of a type that is eligible to order, certify, or prescribe.
- The supplier no longer meets the licensure, certification or educational requirements for his or her supplier type.
- The supplier is excluded per the Medicare Exclusion Database (MED) and/or debarred per the System for Award Management (SAM).

For purposes of the Form CMS-855O only, the term “revocation” effectively means that:

- The supplier may no longer order or certify Medicare services based on his or her having completed the Form CMS-855O process.
- If the supplier wishes to submit another Form CMS-855O, he or she must do so as an initial applicant.

There are appeal rights associated with the revocation of a supplier’s Form CMS-855O enrollment.

i. 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.

3. Form CMS-855O Processing Guide

Go to <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019033.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending> to view the CMS-855O Processing Guide, which constitutes a general Form CMS-855O processing guide for providers/suppliers and contractors. The procedures described in the Guide, which include processing alternatives and processing instructions for the Form CMS-855O, take precedence over all other instructions in this chapter concerning the processing of Form CMS-855O applications.

F. CMS-855S – Medicare Enrollment Application for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers

This application should be completed by suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS). The National Supplier Clearinghouse (NSC) is responsible for processing this type of enrollment application.

1. Sections of the CMS-855S

a. Basic Information (Section 1)

In this section, the supplier indicates the reason for submittal of the application. Unless otherwise stated in this chapter or in another CMS directive, the supplier may only check one reason for submittal. Additionally, the supplier will identify their business and business location in this section.

b. Identifying Information (Section 2)

Unavoidable Phone Number or Address Changes – Unless CMS specifies otherwise, any change in the supplier's phone number or address that the supplier did not cause (i.e., area code change, municipality renames the supplier's street) must still be updated via the Form CMS-855.

Additional information to be included in this section:

- i. Except for locations used only as warehouse and/or repair facilities, suppliers must submit a completed Form CMS-855S application for each physical location. Each address must be a street address as recorded by the USPS and P.O. boxes will not be accepted.
- ii. Suppliers must list their posted hours of operation as displayed at the aforementioned business location. Unless otherwise stated in this chapter, or in another CMS directive, the supplier shall have a minimum of 30 hours of operation per week.

c. Products/Accreditation Information (Section 3)

Please refer to section 10.2.5(A)(2) for information on Accreditation requirements.

Note: The paper CMS-855S contains Products/Accreditation Information in Section 3, however this information is found in Section 2 in PECOS.

d. Important Address Information (Section 4)

Refer to the Important Address Information section of the CMS Form-855S for information concerning important address information.

e. Comprehensive Liability Insurance Information (Section 5)

Refer to Comprehensive Liability Insurance Information section of the CMS Form-855S for information concerning liability insurance information.

Note: The paper CMS-855S contains the Comprehensive Liability Insurance Information in Section 5, however this information is found in Section 7 in PECOS.

f. Surety Bond Information (Section 6)

Please refer to section 10.2.5(A)(3) for information on Surety Bond requirements.

Note: The paper CMS-855S contains Surety Bond Information in Section 6, however this information is found in Section 7 in PECOS.

g. Final Adverse Legal Actions/Convictions (Section 7)

Refer to Section 10.6.6 of this chapter for information regarding final adverse actions.

Note: The paper CMS-855S contains Final Adverse Legal Actions/Convictions in Section 7, however this information is found in Section 3 in PECOS.

h. Ownership Interest and/or Managing Control Information (Organizations) (Section 8)

Regarding the Billing Agency section of the Form CMS-855S Refer to Section 10.6.7(A) – Owning and Managing Organizations and section 10.6.7(C) – Tax Identification Numbers (TINs) of Owning and Managing Organizations and Individuals.

Note: The paper CMS-855S contains Ownership Interest and/or Managing Control Information (Organizations) in Section 8, however this information is found in Section 5/6 in PECOS.

i. Ownership Interest and/or Managing Control Information (Individuals) (Section 9)

Regarding the Individual Ownership Interest and/or Managing Control Information section of the Form CMS-855S, refer to section 10.6.7(B) Owning and Managing Individuals and section 10.6.7(C) – Tax Identification Numbers (TINs) of Owning and Managing Organizations and Individuals.

Note: The paper CMS-855S contains Ownership Interest and/or Managing Control Information (Individuals) in Section 9, however this information is found in Section 5/6 in PECOS.

j. Billing Agency Information (Section 10)

Regarding the Billing Agency Information section of the Form CMS-855S, refer to section 10.6.8 – Billing Agencies

In addition, regarding the Billing Agency section of the Form CMS-855S, if the telephone number is blank, the number can be verified with the supplier by telephone, e-mail or fax. If the section is blank, including the check box, no additional development is necessary.

Note: The paper CMS-855S contains Billing Agency Information in Section 10, however this information is found in Section 8 in PECOS.

k. Contact Person Information (Section 11)

Regarding the Contact Person Information section of the Form CMS-855S, refer to Section 10.6.9 (of this chapter) Contact Persons.

If this section is completely blank, the contractor need not develop for this information and can simply contact an authorized or delegated official.

If neither box is checked but the contact person information is incomplete (e.g., no telephone number listed), the contractor can either: (1) develop for this information by telephone, e-mail or fax, or (2) contact an authorized or delegated official.

Currently there is no option on the CMS-855S form to delete a contact person. Therefore, contractors shall accept end dates of a contact person via phone, email, fax or mail from the individual provider, the Authorized or Delegation official, or a current contact person on file. Contractors shall document in the comment section in PECOS who requested the termination, how it was requested (email, phone or fax) and when it was requested. The addition of contact persons must still be reported via the appropriate CMS-855S form.

Note: The paper CMS-855S contains Contact Person Information in Section 11, however this information is found in Section 13 in PECOS.

I. Supporting Documents (Section 12)

Refer to the Supporting Documents section of the CMS Form-855S for information concerning supporting documents.

m. Penalties for Falsifying Information (Section 13)

Please refer to the Penalties for Falsifying Information section of the Form CMS-855S for an explanation of penalties that apply to suppliers for deliberately furnishing false information in this application to gain or maintain enrollment in the Medicare program.

n. Assignment of Delegated Officials (Section 14)

A delegated official is an individual to whom an authorized official listed in the Assignment of Delegated Officials section of the Form CMS-855 delegates the authority to report changes and updates to the provider's enrollment record or to sign revalidation applications. The delegated official's signature binds the organization both legally and financially, as if the signature was that of the authorized official. Before the delegation of authority is established, the only acceptable signature on the enrollment application to report updates or changes to the enrollment information is that of the authorized official currently on file with Medicare. The delegated official must be an individual with an "ownership or control interest" in (as that term is defined in §1124(a)(3) of the Social Security Act), or be a W-2 managing employee of the provider.

Section 1124(a)(3) defines an individual with an ownership or control interest as:

- A five percent direct or indirect owner of the provider,
- An officer or director of the provider (if the provider is a corporation), or

- Someone with a partnership interest in the provider, if the provider is a partnership

The delegated official must be a delegated official of the supplier, not of an owning organization, parent company, chain home office, or management company. One cannot use his/her status as a W-2 managing employee of the provider's parent company, management company, or chain home office as a basis for his/her role as the provider's delegated official.

The Ownership Interest and Managing Control Information in the Individual Ownership Interest and/or Managing Control Information section of Form CMS-855S must be completed for all delegated officials.

A delegated official has no authority to sign an initial application. However, the delegated official may (i) sign a revalidation application and (ii) sign off on changes/updates submitted in response to a contractor's request to clarify or submit information needed to continue processing the provider's initial application.

Further Delegation - Delegated officials may not delegate their authority to any other individual. Only an authorized official may delegate the authority to make changes and/or updates to the provider's Medicare data or to sign revalidation applications.

Regarding managing employees, for purposes of the Delegated Officials information captured in the Individual Ownership Interest and/or Managing Control Information section only, the term "managing employee" means any individual, including a general manager, business manager, or administrator, who exercises operational or managerial control over the provider, or who conducts the day-to-day operations of the provider. However, this does not include persons who, either under contract or through some other arrangement, manage the day-to-day operations of the provider but who are not actual W-2 employees. For instance, suppose the provider hires Joe Smith as an independent contractor to run its day-to-day-operations. Under the definition of "managing employee" in the Individual Ownership and/or Managing Control section of the Form CMS-855, Smith would have to be listed in that section. Yet under the Individual Ownership and/or Managing Control section definition (as described above), Smith cannot be a delegated official because he is not an actual W-2 employee of the provider. Independent contractors are not considered "managing employees" under the Individual Ownership and/or Managing Control section of the Form CMS-855.

i. W-2 Form

Unless the contractor requests it to do so, the provider is not required to submit a copy of the owning/managing individual's W-2 to verify an employment relationship.

ii. Number of Delegated Officials

The provider can have as many delegated officials as it chooses. Conversely, the provider is not required to have any delegated officials. Should no delegated officials be listed, the authorized official(s) remains the only individual(s) who can report changes and/or updates to the provider's enrollment data.

iii. Effective Date

The effective date in PECOS for the Assignment of Delegated Officials section of the Form CMS-855S should be the effective date listed in the Assignment of Delegated Officials section of the CMS-855S or the receipt date of the CMS-855S application.

iv. Social Security Number

To be a delegated official, the person must have and must submit his/her social security number. An Individual Taxpayer Identification Number (ITIN) cannot be used in lieu of an SSN in this regard.

v. Deletion of a Delegated Official

If a delegated official is being deleted, documentation verifying that the person no longer is or qualifies as a delegated official is not required. Also, the signature of the deleted official is not needed.

vi. Delegated Official Not on File

If the provider submits a change of information (e.g., change of address) and the delegated official signing the form is not on file, the contractor shall ensure that (1) the person meets the definition of a delegated official, (2) the Individual Ownership and/or Managing Control section of the Form CMS-855 is completed for that person, and (3) an authorized official signs off on the addition of the delegated official. (NOTE: The original change request and the addition of the new official shall be treated as a single change request (i.e., one change request encompassing two different actions) for purpose of enrollment processing and reporting.)

vii. Signature on Paper Application

If the provider submits a paper Form CMS-855 change request, the contractor may accept the signature of a delegated official in the Assignment of Delegated Officials or Authorized Official Certification Statement and Signature sections of the Form CMS-855.

In addition, the Delegated Official's telephone number can be left blank. No further development is needed.

Note: The paper CMS-855S contains Assignment of Delegated Officials in Section 15, however this information is found in Section 15/16 in PECOS.

o. Authorized Official Certification Statement and Signature (Section 15)

The provider may submit their certification statement via e-signature or paper to their contractor.

For Form CMS-855S initial applications, the certification statement must be signed and dated by an authorized official of the provider or supplier. (See section 10.1.1 and 10.3.1(F)(1)(n) of this chapter for a definition of "authorized official."). This applies to: (1) signatures on the paper Form CMS-855, (2) signatures on the certification statement for Internet-based Provider Enrollment, and electronic signatures.

For Form CMS-855S applications submitted to change, update and/or revalidate the provider or supplier's Medicare enrollment data, the certification statement may be signed and dated by the authorized or delegated official of the provider or supplier. This applies to: (1) signatures on the paper Form CMS-855, (2) signatures on the certification statement for Internet-based Provider Enrollment, and electronic signatures.

Valid signatures include handwritten (wet) signatures in ink and digital/electronic signatures (digital or electronic signatures such as those created by digital signature options, created in software, such as Adobe) shall be accepted. Contractors shall contact their PEOG BFL for questions regarding electronic signatures.

All signatures (handwritten or digital) are valid and appropriate in regards to (1) signatures on the paper Form CMS-855S (2) uploaded signatures on the certification statement for Internet-based Provider Enrollment, Chain and Ownership System (PECOS) applications.

Note: The paper CMS-855S contains Authorized Official Certification Statement and Signature in Section 14, however this information is found in Section 15/16 in PECOS.

p. Medicare Supplier Enrollment Application Privacy Statement

All information collected on form CMS-855S shall be entered into the Provider Enrollment, Chain and Ownership System (PECOS). The Privacy Act permits CMS to disclose information without an individual's consent if the information is to be used for a purpose that is compatible with the purpose(s) for which the information was collected. Any such disclosure of data is known as a "routine use." The CMS will only release PECOS information that can be associated with an individual as provided for under Section III "Proposed Routine Use Disclosures of Data in the System." Both identifiable and non-identifiable data may be disclosed under a routine use. CMS will only collect the minimum personal data necessary to achieve the purpose of PECOS. To view the routine uses in their entirety go to: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/Privacy/Downloads/0532-PECOS.pdf>.

2. Additional Processing Information and Alternatives for Form CMS-855S

a. Unsolicited Additional Information

Regarding unsolicited additional information, if the provider submits missing/clarifying data or documentation on its own volition (i.e., without being contacted by the contractor), the contractor shall include this additional data/documentation in its overall application review. Any new or changed information that a provider submits prior to the date the contractor finishes processing a previously submitted change request is no longer considered to be an update to that change request. Rather, it is considered to be and shall be processed as a separate change request. The contractor may process both changes simultaneously, but the change that was submitted first shall be processed to completion prior to the second one being processed to completion.

b. Information Disclosed Elsewhere

If a data element on the supplier's Form CMS-855S application is missing but the information is disclosed: (1) elsewhere on the application or (2) in the supporting documentation submitted with the application, the contractor need not obtain the missing data via an updated Form CMS-855S page and a newly-signed certification statement; no

further development – not even by telephone – is required. The following information, however, must be furnished in the appropriate section(s) of the Form CMS-855S, even if the data is identified elsewhere on the form or in the supporting documentation:

- Any final adverse action data requested in the Final Adverse Legal Actions section, and the Final Adverse Legal Action History of the Organizational and Individual Ownership and/or Managing Control sections of the Form CMS-855S.
- Tax identification numbers (TIN)
- Supplier type in the Products/Accreditation Information section of the Form CMS-855S

If the supporting documentation currently exists in the provider's file, the provider or supplier is not required to submit that documentation again during the enrollment process. The MAC shall utilize the existing documentation for verification. Documentation submitted with a previously submitted enrollment application, or documentation currently uploaded in PECOS, qualifies as a processing alternative, unless stated otherwise in this chapter or any CMS directive. Also, per section 10.6.19(H) of this chapter, the contractor shall document in the provider file that the missing information was found elsewhere in the enrollment package. This excludes information that must be verified at the current point in time (i.e. a license without a primary source verification method). Additionally, contractors shall not utilize information submitted along with opt-out applications for enrollment application processing or vice-versa.

10.3.2 – CMS-20134 – Enrollment Form: Information and Processing (Rev. 10524; Issued: 12-17-20; Effective: 11-13-20; Implementation: 11-13-20)

A. CMS-20134 – Medicare Enrollment Application for Medicare Diabetes Prevention Program (MDPP) Suppliers

This application should be completed by organizations furnishing MDPP services to Medicare beneficiaries. In-Person MDPP suppliers participating in the Center for Medicare and Medicaid Innovation's expanded model, which exclusively furnishes MDPP to beneficiaries in in-person settings with limited exceptions for virtual makeup sessions, may begin enrolling into Medicare on January 1, 2018.

1. Sections of the CMS-20134 and Processing Information

a. Basic Information (Section 1)

In this section, the provider or supplier indicates the reason for submittal of the application. Unless otherwise stated in this chapter or in another CMS directive, the provider may only check one reason for submittal.

For example, suppose a supplier is changing its tax identification number. The supplier must submit two applications: (1) an initial Form CMS-20134 as a new supplier, and (2) a Form CMS-20134 voluntary termination. Both transactions cannot be reported on the same application.

With the exception of: (1) the voluntary termination checkbox and (2) the effective date of termination data in the Basic Information section of the Form CMS-20134, any blank

data/checkboxes in the Basic Information section can be verified through any means chosen by the contractor (e.g., e-mail, telephone, fax).

i. CDC DPRP Recognition

To be eligible to enroll as an MDPP supplier, entities must have either:

- MDPP Preliminary recognition or
- CDC DPRP Full Recognition

Note that MDPP preliminary recognition includes both Interim Preliminary Recognition as designated by CMS as well as preliminary DPRP recognition as designated by the CDC.

Certificates or letters of the above recognitions are the only eligibility documents required by Medicare to function as the supplier type in question. Any other licenses, certificates, and permits that are not of a medical nature or are of a medical nature, but not related to MDPP are not required.

To verify recognition status information, the contractor shall also adhere to the following:

- Verify that certificate or letter submitted with the organization's application indicates that the organization has met preliminary or full recognition with an effective date within a year of the application
- Verify that the organization code indicated in the Identifying Information section of the CMS-20134 matches both the organization code on the provided CDC registry and on the certificate.
- Verify that the provided CDC registry indicates that the entity associated with that organizational code has met the recognition level (preliminary or full) indicated on the CMS-20134
- Verify that name associated with the organizational code on CDC's registry is consistent with the name that is listed on the certificate or letter confirming recognition status.

A. Recognition Status

In situations where an MDPP supplier is required to submit a copy of its CDC recognition but fails to do so, the contractor need not obtain such documentation from the supplier if the contractor can verify the information independently. This may be done by: (1) reviewing and printing confirming pages from the Centers for Disease Control and Prevention Web site, (2) requesting and receiving from the CDC written confirmation of the supplier's status therewith, or (3) utilizing another third-party verification source. Similarly, if the supplier submits a copy of the applicable recognition, but fails to complete the applicable section of the form, the section need not be completed if the data in question can be verified on the recognition itself or via any of the three mechanisms described above. The contractor shall not develop for a correction to the form if the recognition information can be verified as described above.

The above-referenced written confirmation of the supplier's status can be in the form of a letter, fax, or email, but it must be in writing. Documentation of a verbal conversation between the contractor and the body in question does not qualify as appropriate confirmation.

b. Identifying Information (Specific to MDPP Form Identifying Info) (Section 2)

i. Correspondence Address and Telephone Number

Regarding the correspondence address in the Correspondence Address section of the Form CMS-20134, 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. The contractor is not required to verify the correspondence address. 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.

Regarding the telephone number in the Correspondence Address section of the Form CMS-20134, the provider may list any telephone number it wishes as the correspondence phone number. The number need not link to the listed correspondence address. If the provider fails to list a correspondence telephone number and it is required for the application submission, the contractor shall develop for this information – preferably via email or fax. The contractor shall accept a particular phone number if it has no reason to suspect that it does not belong to or is not somehow associated with the provider. The contractor is not required to verify the telephone number.

ii. 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.

Regarding unavoidable phone number or address changes, unless CMS specifies otherwise, any change in the provider's phone number or address that the provider did not cause (i.e., area code change, municipality renames the provider's street) must still be updated via the Form CMS-20134.

iii. Supplier Identification Information

Regarding Supplier Identification Information – Business Information, the contractor may capture all information in the Identifying Information (Business Information) section (with the exception of the TIN and LBN) by telephone, fax, e-mail, or a review of the provider or supplier's Web site.

c. Final Adverse Legal Actions/Convictions (Section 3)

Refer to Section 10.6.6 of this chapter for information regarding final adverse actions.

d. MDPP Location Information (Section 4)

The MDPP location address must be a valid address with the United States Postal Service (USPS). Addresses entered into PECOS are verified via computer software to determine if they are valid and deliverable.

Regarding the contractor's verification of practice locations, the contractor shall verify that the practice locations listed on the application actually exist and is a valid address with the United States Postal Service (USPS). PECOS includes a USPS Address Matching System Application Program Interface (API), which validates address information entered and flags the address if it is determined to be invalid, unknown, undeliverable, vacant, unlikely to deliver mail (No-Stat), a CMRA (i.e., UPS Store, mailboxes, etc.) or a known invalid address false positive. These address types are not permitted in PECOS and are flagged upon entry.

The contractor shall also verify that the reported telephone number is operational and connects to the practice location/business listed on the application. However, the contractor need not contact every location for applicants that are enrolling multiple locations; the contractor can verify each location's telephone number with the contact person listed on the application and note the verification accordingly in the contractor's verification documentation per section 10.6.19(H) of this chapter. (The telephone number must be one where patients and/or customers can reach the applicant to ask questions or register complaints.) The contractor may also match the applicant's telephone number with known, in-service telephone numbers - via, for instance, the Yellow Pages or the Internet - to correlate telephone numbers with addresses. If the applicant uses his/her/its cell phone for their business, the contractor shall verify that this is a telephone connected directly to the business. If the contractor cannot verify the telephone number, it shall request clarifying information from the applicant; the inability to confirm a telephone number may indicate that an onsite visit is necessary. In some instances, a 1-800 number or out-of-state number may be acceptable if the applicant's MDPP location is in another State but his/her/its practice locations are within the contractor's jurisdiction.

Any supplier submitting a Form CMS-20134 application must submit the 9-digit ZIP Code for each practice location listed.

For suppliers paid via the Multi-Carrier System (MCS), the practice location name entered into PECOS shall be the legal business name.

In the MDPP Location Information section of the Form CMS-20134, the type of MDPP location checkboxes need to be completed to indicate if the location is the MDPP supplier's Administrative Location or the Community setting. If the type of location is apparent to the contractor, the MDPP supplier does not need to complete the Administrative location type, if the type of location is apparent. The contractor can confirm the information via telephone, e-mail, or fax.

In the MDPP Location Information/Remittance Notice and Special Payments Address section of the Form CMS-20134, if neither box is checked and no address is provided, the contractor can contact the supplier by telephone, e-mail, or fax to confirm the supplier's intentions. If the "special payments" address is indeed the same as the practice location, no further development is needed. If, however, the supplier wants payments to be sent to a different address, the address in 4B must be completed via the Form CMS-20134.

- Each administrative location is to be verified. However, there is no need to separately contact each location on the application. Such verification can be done via the contact person listed on the application; the contact person's verification shall be documented in the provider file pursuant to section 10.6.19(H) of this chapter.

i. Do Not Forward (DNF)

Unless instructed otherwise in another CMS directive, the contractor shall follow the DNF initiative instructions in Pub. 100-04, chapter 1, section 80.5. Returned paper checks, remittance notices, or EFT payments shall be flagged if returned from the post office or banking institution, respectively, as this may indicate that the provider's "special payment" address (Practice Location section of the CMS-20134) or EFT information has changed. The provider should submit a CMS-20134 or CMS-588 request to change this address; if the provider does not have an established enrollment record in the Provider Enrollment, Chain and Ownership System, it must complete an entire Form CMS-20134 and Form CMS-588. The Durable Medical Equipment MAC is responsible for obtaining, updating and processing Form CMS-588 changes.

In situations where a provider is closing his/her/its business and has a termination date (e.g., he/she is retiring), the contractor will likely need to make payments for prior services rendered. Since the practice location has been terminated, the contractor may encounter a DNF message. If so, the contractor should request the provider to complete the "special payment" address section of the Form CMS-20134 and to sign the certification statement. The contractor, however, shall not collect any other information unless there is a need to do so.

ii. Remittance Notices/Special Payments

For new enrollees, all payments must be made via EFT. The contractor shall thus ensure that the provider has completed and signed the Form CMS-588 and shall verify that the bank account is in compliance with Pub. 100-04, chapter 1, section 30.2.

If an enrolled provider that currently receives paper checks submits a Form CMS-20134 change request – no matter what the change involves – the provider must also submit:

- A Form CMS-588 that switches its payment mechanism to EFT. (The change request cannot be processed until the Form CMS-588 is submitted.) All future payments (excluding special payments) must be made via EFT.
- The contractor shall also verify that the bank account is in compliance with Pub. 100-04, chapter 1, section 30.2.

(Once a provider changes its method of payment from paper checks to EFT, it must continue using EFT. A provider cannot switch from EFT to paper checks.)

The "special payment" address may only be one of the following:

- One of the provider's practice locations
- A P.O. Box

- The provider's billing agent. The contractor shall request additional information if it has any reason to suspect that the arrangement – at least with respect to any special payments that might be made – may violate the Payment to Agent rules in Pub. 100-04, chapter 1, section 30.2.
- The chain home office address. Per Pub.100-04, chapter 1, section 30.2, a chain organization may have payments to its providers sent to the chain home office. The legal business name of the chain home office must be listed on the Form CMS-588. The TIN on the Form CMS-588 should be that of the provider.
- Correspondence address
- A Lock Box

iii. Additional MDPP Supplier Location Information:

The MDPP set of services is unique in that it is delivered in group settings and can be delivered by non-traditional health care providers who meet certain eligibility criteria. Given this aspect of MDPP suppliers, MDPP services are often delivered within community locations to increase access. Thus, the locations associated with MDPP suppliers differ slightly than traditional practice locations of other health care provider and suppliers.

MDPP suppliers must have at least one administrative location, and must report all administrative locations on their Form CMS-20134 or PECOS equivalent. As noted in section 10.1.1, an administrative location is the physical location associated with the supplier's operations, from where coaches are dispatched or based, and where MDPP services may or may not be furnished. If an entity enrolls as an MDPP supplier, but does not furnish MDPP services at their administrative location, it should deliver and disclose any and all community settings where they furnish MDPP services. With respect to MDPP, a community setting is a location where the supplier furnishes MDPP services outside of their administrative locations in a meeting location open to the public, but not primarily associated with the supplier.

A. Administrative Locations

All administrative locations associated with the supplier must be disclosed on the enrollment application. Administrative locations must:

- Not be a private residence.
- Must have signage posted on the exterior of the building or suite, in a building directory, or on materials located inside of the building. Such signage may include, for example, the MDPP supplier's legal business name or DBA, as well as hours of operation.
- Must be open for business and have employees, staff, or volunteers present during operational hours.

All administrative locations related to the MDPP supplier must be disclosed, however, given that MDPP suppliers may be non-traditional health care providers engaged in non-health care related activities, not all organizations run by the entity may constitute an

administrative location. For example, if an advocacy organization operated 2 sites, however only one of these sites offered MDPP services, only the site offering MDPP would be considered an administrative location. Should a coach be based or dispatched from their non-administrative location site to offer MDPP services in community settings, that location would become an administrative location. Detail on the frequency with which MDPP suppliers must report this change is outlined in Section 10.2.6 of this chapter.

Given that MDPP suppliers are designated as high categorical risk, their administrative locations are subject to site visits. Additional information for the site visit is outlined in Section 10.5 of this chapter.

B. Community Settings

When determining whether a location is considered an administrative location or a community setting, MDPP suppliers must consider whether their organizational entity is the primary user of that space and whether coaches are based or dispatched from this location. If so, the location would be considered an administrative location, even if this location dually provides other services benefiting the community. In comparison, community settings are locations not primarily associated with the supplier where many activities occur, including MDPP services.

MDPP suppliers are required to update their enrollment application with locations where services are furnished in community settings. These settings are not subject to site visits, but serve a form of recordkeeping and accountability for the MDPP supplier.

C. Out-of-State Practice Locations

If a supplier is adding a practice location in another State that is within the contractor's jurisdiction, a separate, initial Form CMS-20134 enrollment application is not required if the following 2 conditions are met:

- The location is not part of a separate organization (e.g., a separate corporation, partnership),
- The location does not have a separate tax identification number (TIN) and legal business name (LBN),

e. Ownership Interest and/or Managing Control Information (Sections 5 & 6)

Regarding the Organizational Ownership and/or Managing Control section of the Form CMS-20134 Refer to Section 10.6.7(A) – Owning and Managing Organizations and section 10.6.7(C) – Tax Identification Numbers (TINs) of Owning and Managing Organizations and Individuals

Regarding the Individual Ownership and/or Managing Control section of the Form CMS-20134, refer to section 10.6.7(B) Owning and Managing Individuals and section 10.6.7(C) – Tax Identification Numbers (TINs) of Owning and Managing Organizations and Individuals

f. Coach Roster (Section 7)

i. Background Information

Only organizations, and not individuals, are eligible to enroll as an MDPP supplier. However, MDPP services are furnished to Medicare beneficiaries by MDPP coaches in group settings. Though these individuals furnish MDPP services on behalf of MDPP suppliers, only the MDPP supplier itself enrolls in Medicare. To enable CMS to better ensure the integrity of the program and the safety of the beneficiaries it serves, MDPP suppliers are required to report identifying information of coaches on their enrollment application, in the Coach Roster section of the Form CMS-20134. If a coach is being added or changed, the updated information must be reported via a Form CMS-20134 change request

ii. Coach Eligibility and Screening

As indicated Section 10.2.6, the MDPP supplier standards indicate that MDPP suppliers may not include on their roster or allow MDPP services to be furnished by an ineligible coach. CMS indicates that, to furnish MDPP services to a beneficiary, an MDPP coach must not:

- Currently have Medicare billing privileges revoked and be currently subject to a reenrollment bar.
- Currently have its Medicaid billing privileges terminated for-cause or be excluded by a State Medicaid agency.
- Currently be excluded from 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.
- Currently be debarred, suspended, or otherwise excluded from participating in any other Federal procurement or nonprocurement program or activity in accordance with the Federal Acquisition Streamlining Act implementing regulations and the Department of Health and Human Services nonprocurement common rule at 45 CFR part 76.
- Have, in the previous 10 years, one of the following State or Federal felony convictions:
 - Crimes against persons, such as murder, rape, assault, and other similar crimes for which the individual was convicted, as defined under 42 CFR 1001.2, had a guilty plea or adjudicated pretrial diversion.
 - Financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, as defined under 42 CFR 1001.2, had a guilty plea or adjudicated pretrial diversion.
 - Any felony that placed the Medicare or its beneficiaries at immediate risk, such as a malpractice suit that results in the individual being convicted, as defined under 42 CFR 1001.2, had a guilty plea or adjudicated pretrial diversion of criminal neglect or misconduct.

- Any felonies for which the individual was convicted, as defined under 42 CFR 1001.2, had a guilty plea or adjudicated pretrial diversion that would result in mandatory exclusion under section 1128(a) of the Act.

Upon enrollment or any changes to the Coach Roster section of the Form CMS-20134 that results in a new coach being added, Medicare Contractors are to confirm that the coach is not presently excluded from the Medicare program by the HHS Office of the Inspector General (OIG) or through the System for Award Management (SAM) (formerly, the General Services Administration Excluded Parties List System) and, to the extent possible, whether or not an individual coach meets the above eligibility criteria. Should the contractor identify that an ineligibility criteria has been met as a result of that screening, but have questions as to whether it would qualify as meeting an ineligibility criteria, they should contact PEOG.

If a coach is being added or changed, the updated information must be reported via a Form CMS-20134 change request.

If the date of change for an individual coach is completely blank, the contractor must develop for this information.

iii. Coach Eligibility Start and End Dates

MDPP coaches may be expected to have a high turnover rate. To document which coaches are active with a supplier at a given time, each coach will have an eligibility start and, if applicable, an eligibility end date.

For each change to the Coach Roster section of the Form CMS-20134, the MDPP supplier must indicate a date of such change. For changes that result in a coach being added, either from an initial enrollment or a change of information to add a new coach to the MDPP supplier's roster, the date of the change becomes the coach's eligibility start date. Dates may be post-dated into the future. MDPP supplier may also include eligibility start dates in the past. However, per, 42 CFR 424.205(d), MDPP suppliers must report all changes to the coach roster within 30 days of such a change. Thus, if an MDPP supplier adds a coach with an effective date more than 30 days prior to the date of the supplier is making the change, the Contractor shall revoke the MDPP supplier under 42 CFR 424.530(a)(1) for non-compliance with the MDPP supplier standards. For example, if the MDPP supplier is already enrolled and on May 1, 2018 submits a change of information to add a new coach, but indicates its eligibility start date as March 1st, the MDPP supplier would not be complying with MDPP supplier standards. In this scenario, the Contractor may develop to obtain the correct effective date on the application.

If the Contractor determines the coach to be ineligible, the coach's eligibility start and end date shall be documented as the same date, therefore the coach was never eligible. Coaches may also get eligibility end dates if the MDPP supplier removes that coach from their roster. In this case, the eligibility end date would be the date the MDPP supplier indicated when they updated the Coach Roster section to remove the coach. Similarly, to eligibility start dates, an MDPP supplier may include a date that is within 30 days in the future or 30 days in the past of the date they are making the change. The contractor may return the application if the start date is more than 30 days in the future. Lastly, a coach may also receive an eligibility end date if the MDPP supplier to which they are associated is revoked or does not revalidate its enrollment. In this scenario, the

coach's eligibility end date is the same date as the date the MDPP supplier's billing privileges were no longer effective.

An MDPP supplier may only be paid for services furnished by eligible coaches within their eligibility start and end dates.

iv. Consequences for Coach Ineligibility

If Medicare contractors or CMS directly determines that an MDPP supplier has an ineligible coach on its roster, then the MDPP coach would be non-compliant with the MDPP supplier standards, and would have their enrollment denied or revoked, as appropriate under 424.430(a)(1) or 424.435(a)(1). As with existing procedures, MDPP suppliers would have the opportunity to submit a corrective action plan (CAP) removing this coach from its roster within 30 days of receiving notice of its enrollment denial or revocation, and, if compliant, could maintain their Medicare enrollment.

In this case, MDPP suppliers need not submit any additional documentation, however, they must update the Coach Roster section of the Form CMS-20134 to remove the ineligible coach. No further documentation is necessary.

v. Special Revocation for Knowingly Using an Ineligible Coach

While MDPP supplier standards indicate that MDPP suppliers may not include ineligible coaches on its roster or allow them to furnish MDPP services on their behalf to Medicare beneficiaries, it does not prohibit the MDPP supplier to continue to employ or allow the coach to volunteer for other services unrelated to MDPP. Should CMS identify that an MDPP supplier is knowingly allowing an ineligible coach to continue furnishing MDPP services, the MDPP supplier would be revoked under a new revocation authority at §424.205(h)(5), and any other revocation authority that may apply.

In this context, knowingly means that the MDPP supplier received an enrollment denial or revocation notice based on failing to meet the standard specified in §424.205(d)(3), was provided notice by CMS or contractors working on its behalf of this coach's ineligibility including the reason(s) for ineligibility, submitted a CAP to remove the coach, then became compliant once again and maintained its enrollment, but continued to allow the ineligible coach removed from the Coach Roster section of the Form CMS-20134 to provide MDPP services in violation of the CAP.

Further details are outlined in section 10.4(M)(4)(d).

g. Billing Agency Information (Section 8)

Regarding the Billing Agency Information section of the Form CMS-20134, refer to section 10.6.8 – Billing Agencies

In addition, regarding the Billing Agency Information section of the Form CMS-20134, if the telephone number is blank, the number can be verified with the supplier by telephone, e-mail or fax. If the section is blank, including the check box, no additional development is necessary.

h. Contact Person (Section 13)

Regarding the Contact Person section of the Form CMS-20134, refer to Section 10.6.9 (of this chapter) Contact Persons.

If this section is completely blank, the contractor need not develop for this information and can simply contact an authorized or delegated official.

If neither box is checked but the contact person information is incomplete (e.g., no telephone number listed), the contractor can either: (1) develop for this information by telephone, e-mail or fax, or (2) contact an authorized or delegated official.

Currently there is no option on the CMS-20134 form to delete a contact person. Therefore, contractors shall accept end dates of a contact person via phone, email, fax or mail from the individual provider, the Authorized or Delegation official, or a current contact person on file. Contractors shall document in the comment section in PECOS who requested the termination, how it was requested (email, phone or fax) and when it was requested. The addition of contact persons must still be reported via the appropriate CMS-20134 form.

i. Penalties for Falsifying Information (Section 14)

Please refer to the Penalties for Falsifying Information section of the Form CMS-20134 for an explanation of penalties that apply to providers and suppliers for deliberately furnishing false information in this application to gain or maintain enrollment in the Medicare program.

j. Certification Statement (Section 15)

Unless indicated otherwise below or in another CMS directive, the instructions in this subsection apply to (1) signatures on the paper Form CMS-20134, (2) signatures on the certification statement for Internet-based Provider Enrollment, Chain and Ownership System (PECOS) applications, and (3) electronic signatures

Valid signatures include handwritten (wet) signatures in ink and digital/electronic signatures (digital or electronic signatures such as those created by digital signature options, created in software, such as Adobe) shall be accepted. Contractors shall contact their PEOG BFL for questions regarding electronic signatures.

All signatures (handwritten or digital) are valid and appropriate in regards to (1) signatures on the paper Form CMS-855R (2) uploaded signatures on the certification statement for Internet-based Provider Enrollment, Chain and Ownership System (PECOS) applications.

The provider may submit their certification statement via e-signature or paper to their contractor. See section 10.3.2(A)(1)(j) for further instructions on certification statement submissions.

i. Paper Submissions

A signed certification statement shall accompany the paper CMS-20134. If the provider submits an invalid certification statement or fails to submit a certification statement, the contractor shall still proceed with processing the application. An appropriate certification statement shall be solicited as part of the development process – preferably via email or fax. This includes certification statements that are: (a) unsigned; (b) undated; (c) was signed (as reflected by the date of signature) more

than 120 days prior to the date on which the contractor received the application); (d) missing certification statements, or (e) stamped. The contractor shall send one development request to include a list of all of the missing required data/documentation, including the certification statement. The contractor may reject the provider's application if the provider fails to furnish the missing information on the enrollment application - including all necessary documentation - within 30 calendar days from the date the contractor requested the missing information or documentation. Unless stated otherwise in this chapter or in another CMS directive:

- The contractor shall begin processing the application upon receipt and shall develop for missing certification statements and all other missing information, including application fee, upon review.
- The certification statement may be returned via scanned email or fax.
- Signature dates cannot be prior to 120 days of the receipt date of the application.
- For paper applications that require development, it is only necessary that the dated signature of at least one of the provider's authorized or delegated officials be on the certification statement that must be sent in within 30 days; obtaining the signatures of the other authorized and delegated officials is not required.
- For paper changes of information applications (as the term "changes of information" is defined in section 10.4(J) of this chapter), if the certification statement is signed by an individual who is not on file with the contractor as being an authorized or delegated official of the provider, the contractor may accept the certification statement but shall develop for information on the person in question in accordance with section 10.3.2(A)(1)(j)(iii) of this chapter.
- The contractor is not required to compare the signature thereon with the same provider, authorized or delegated official's signature on file to ensure that it is the same person. The contractor shall not request the submission of a driver's license or passport to verify a signature.

ii. Certification Statement: Internet-based PECOS Submissions

If the provider submits its application online and chooses to submit its certification statement via paper rather than through e-signature, it shall do so via PECOS upload functionality. The provider shall not mail in its paper certification statement as it will not be accepted. Unless stated otherwise in this chapter or in another CMS directive:

- The contractor shall begin processing the application upon receipt and shall develop for missing certification statements and all other missing information, including application fee, upon review.
- Signature dates cannot be prior to 120 days of the receipt date of the application.
- If the provider submits an invalid certification statement, the contractor shall treat this as missing information and develop for a correct certification statement – preferably via email or fax. This includes certification statements

that are: (a) unsigned; (b) undated; (c) was signed (as reflected by the date of signature) more than 120 days prior to the date on which the contractor received the application); (d) missing certification statements, or (e) stamped. The contractor shall send one development request to include a list of all of the missing required data/documentation, including the certification statement. The contractor may reject the provider's application if the provider fails to furnish the missing 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 Internet-based PECOS applications that require development, it is only necessary that the dated signature of at least one of the provider's authorized or delegated officials be on the certification statement that must be sent in within 30 days; obtaining the signatures of the other authorized and delegated officials is not required.
- For Internet-based PECOS changes of information applications (as the term "changes of information" is defined in section 10.4(J) of this chapter), if the certification statement is signed by an individual who is not on file with the contractor as being an authorized or delegated official of the provider, the contractor may accept the certification statement but shall develop for information on the person in question in accordance with section 10.3.2(A)(1)(j)(iii) of this chapter.
- The contractor is not required to compare the signature thereon with the same provider, authorized or delegated official's signature on file to ensure that it is the same person. The contractor shall not request the submission of a driver's license or passport to verify a signature.

iii. Certification Statement Development

If the provider submits an invalid certification statement (e.g., unsigned; undated; or stamped signature; signed more than 120 days of the receipt date, incorrect individual signed it; not all authorized officials signed it) or neglects to send a certification statement, the contractor shall treat this as missing information and develop for a correct certification statement using the procedures outlined in this chapter. The contractor shall send a development letter to the provider – preferably via email or fax.

Any development requests that require the submission of a newly signed certification statement may be submitted for paper applications via scanned email, fax, or mail; and for web applications by upload, fax, email or e-signature. Only the actual signature page is required; the additional page containing the certification terms need not be submitted. This also applies to the provider's initial submission of a certification statement; such instances require the submission of only the signature page and not the certification terms.

In addition, the Authorized Official's telephone number can be left blank. No further development is needed.

iv. Signatory Requirements

For Form CMS-20134 initial applications, the certification statement must be signed and dated by an authorized official of the provider. (See section 10.1.1 of this chapter for a definition of “authorized official.”) The provider can have an unlimited number of authorized officials, so long as each meets the definition of an authorized official. the Individual Ownership and/or Managing Control section of the Form CMS-20134 must be completed for each authorized official.

If an authorized official is listed as a “Contracted Managing Employee” in the Individual Ownership and/or Managing Control section of the Form CMS-20134 and does not qualify as an authorized official under some other category in this section, he/she cannot be an authorized official.

The contractor shall notify the provider accordingly. If the person is not listed as a “Contracted Managing Employee” in the Individual Ownership and/or Managing Control section and the contractor has no reason to suspect that the person does not qualify as an authorized official, no further investigation is required. Should the contractor have doubts that the individual qualifies as an authorized official, it shall contact the official or the applicant's contact person to obtain more information about the official's job title and/or authority to bind. If the contractor remains unconvinced that the individual qualifies as an authorized official, it shall notify the provider that the person cannot be an authorized official. If that person is the only authorized official listed and the provider refuses to use a different authorized official, the contractor shall deny the application.

An authorized official must be a 5 percent direct owner, chairman of the board, etc., of the enrolling provider. One cannot use his/her status as the chief executive officer, chief financial officer, etc., of the provider’s parent company, management company, or chain home office as a basis for his/her role as the provider’s authorized official.

v. Authorized Officials

An authorized official must be a 5 percent direct owner, chairman of the board, etc., of the enrolling provider with the authority to bind the provider or supplier, both legally and financially, to the requirements set forth in 42 CFR 424.510. This person must also have an ownership or control interest in the provider or supplier, such as, the general partner, chairman of the board, chief financial officer, chief executive officer, president, or hold a position of similar status and authority within the provider or supplier organization. One cannot use his/her status as the chief executive officer, chief financial officer, etc., of the provider’s parent company, management company, or chain home office as a basis for his/her role as the provider’s authorized official.

An authorized official is an appointed official (for example, chief executive officer, chief financial officer, general partner, chairman of the board, or direct owner) to whom the organization has granted the legal authority to enroll it in the Medicare program, to make changes or updates to the organization’s status in the Medicare program, and to commit the organization to fully abide by the statutes, regulations, and program instructions of the Medicare program. An AO is not restricted to the examples of the titles outlined above but is applicable to an equivalent that is an appointed official to whom the organization has granted the legal authority to act on behalf of the organization. These additional titles could include, but are not limited to, executive directors, administrator, president, vice president. Contractors shall consider the individual’s title as well as the authority granted by the

organization when determining whether an individual qualifies as an AO when processing enrollment applications. If the contractor is unsure of an AO's qualifications or authority, they shall contact their Provider Enrollment & Oversight Group Business Function Lead (PEOG BFL) for further clarification. The contractor shall obtain PEOG BFL approval if the only role of the listed AO is "Contracted Managing Employee" despite title and other qualifications, the BFL will confirm authority.

If an authorized official is listed as a "Contracted Managing Employee" in the Individual Ownership and/or Managing Control section of the Form CMS-20134 and does not qualify as an authorized official under some other category in this section, he/she cannot be an authorized official. The contractor shall notify the provider accordingly. If the person is not listed as a "Contracted Managing Employee" in this section and the contractor has no reason to suspect that the person does not qualify as an authorized official, no further investigation is required. Should the contractor have doubts that the individual qualifies as an authorized official, it shall contact the official or the applicant's contact person to obtain more information about the official's job title and/or authority to bind. If the contractor remains unconvinced that the individual qualifies as an authorized official, it shall notify the provider that the person cannot be an authorized official. If that person is the only authorized official listed and the provider refuses to use a different authorized official, the contractor shall deny the application.

For Form CMS-20134 initial applications, the certification statement must be signed and dated by an authorized official of the provider or supplier. (See section 10.1.1 and 10.3.2(A)(1)(j) of this chapter for a definition of "authorized official."). This applies to: (1) signatures on the paper Form CMS-20134, (2) signatures on the certification statement for Internet-based Provider Enrollment, and electronic signatures.

For Form CMS-20134 applications submitted to change, update and/or revalidate the provider or supplier's Medicare enrollment data, the certification statement may be signed and dated by the authorized or delegated official of the provider or supplier. This applies to: (1) signatures on the paper Form CMS-20134, (2) signatures on the certification statement for Internet-based Provider Enrollment, and electronic signatures.

vi. Deletions of Authorized Official

If an authorized official is being deleted, the contractor need not obtain (1) that official's signature, or (2) documentation verifying that the person is no longer an authorized official.

vii. Change in Authorized Officials

A change in authorized officials does not impact the authority of existing delegated officials to report changes and/or updates to the provider's enrollment data or to sign revalidation applications.

viii. Authorized Official Not on File

If the provider submits a change of information (e.g., change of address) and the authorized official signing the form is not on file, the contractor shall ensure that: (1) the person meets the definition of an authorized official, and (2) the Individual Ownership and/or Managing Control section of the Form CMS-20134 is completed for that person. The signature of an existing authorized official is not needed in order to add a new

authorized official. Note that the original change request and the addition of the new official shall be treated as a single change request (i.e., one change request encompassing two different actions) for purpose of enrollment processing and reporting.

ix. Effective Date

The effective date in the Provider Enrollment, Chain and Ownership System for the Certification Statement section of the Form CMS-20134 should be the date of signature.

x. Social Security Number

To be an authorized official, the person must have and must submit his/her social security number (SSN). An Individual Taxpayer Identification Number (ITIN) cannot be used in lieu of an SSN in this regard.

xi. Identifying the Provider

As stated earlier, an authorized official must be an authorized official of the provider, not of an owning organization, parent company, chain home office, or management company. Identifying the provider is not - for purposes of determining an authorized official's qualifications - determined solely by the provider's tax identification number (TIN). Rather, the organizational structure is the central factor. For instance, suppose that a chain drug store, Company X, wants to enroll 100 of its pharmacies with the contractor. Each pharmacy has a separate TIN and must therefore enroll separately. Yet all of the pharmacies are part of a single corporate entity – Company X. In other words, there are not 100 separate corporations in our scenario, but merely one corporation whose individual locations have different TINs. Here, an authorized official for Pharmacy #76, can be someone at X's headquarters (assuming that the definition of authorized official is otherwise met), even though this main office might be operating under a TIN that is different from that of #76. This is because headquarters and Pharmacy #76 are part of the same organization/corporation. Conversely, if #76 was a corporation that was separate and distinct from Company X, only individuals that were part of #76 could be authorized officials.

k. Delegated Officials (Section 16)

A delegated official is an individual to whom an authorized official listed in the Certification Statement section of the Form CMS-20134 delegates the authority to report changes and updates to the provider's enrollment record or to sign revalidation applications. The delegated official's signature binds the organization both legally and financially, as if the signature was that of the authorized official. Before the delegation of authority is established, the only acceptable signature on the enrollment application to report updates or changes to the enrollment information is that of the authorized official currently on file with Medicare. The delegated official must be an individual with an "ownership or control interest" in (as that term is defined in §1124(a)(3) of the Social Security Act), or be a W-2 managing employee of the provider.

Section 1124(a)(3) defines an individual with an ownership or control interest as:

- A five percent direct or indirect owner of the provider,
- An officer or director of the provider (if the provider is a corporation), or

- Someone with a partnership interest in the provider, if the provider is a partnership

The delegated official must be a delegated official of the provider, not of an owning organization, parent company, chain home office, or management company. One cannot use his/her status as a W-2 managing employee of the provider's parent company, management company, or chain home office as a basis for his/her role as the provider's delegated official.

The Ownership Interest and Managing Control Information in the Individual Ownership and/or Managing Control section of Form CMS-20134 must be completed for all delegated officials.

A delegated official has no authority to sign an initial application. However, the delegated official may (i) sign a revalidation application and (ii) sign off on changes/updates submitted in response to a contractor's request to clarify or submit information needed to continue processing the provider's initial application.

Further Delegation - Delegated officials may not delegate their authority to any other individual. Only an authorized official may delegate the authority to make changes and/or updates to the provider's Medicare data or to sign revalidation applications.

Regarding managing employees, for purposes of the Delegated Officials information captured in the Delegated Official section only, the term "managing employee" means any individual, including a general manager, business manager, or administrator, who exercises operational or managerial control over the provider, or who conducts the day-to-day operations of the provider. However, this does not include persons who, either under contract or through some other arrangement, manage the day-to-day operations of the provider but who are not actual W-2 employees. For instance, suppose the provider hires Joe Smith as an independent contractor to run its day-to-day-operations. Under the definition of "managing employee" in the Individual Ownership and/or Managing Control section of the Form CMS-20134, Smith would have to be listed in that section. Yet under the Delegated Official section definition (as described above), Smith cannot be a delegated official because he is not an actual W-2 employee of the provider. Independent contractors are not considered "managing employees" under the Delegated Official section of the Form CMS-20134.

i. W-2 Form

Unless the contractor requests it to do so, the provider is not required to submit a copy of the owning/managing individual's W-2 to verify an employment relationship.

ii. Number of Delegated Officials

The provider can have as many delegated officials as it chooses. Conversely, the provider is not required to have any delegated officials. Should no delegated officials be listed, the authorized official(s) remains the only individual(s) who can report changes and/or updates to the provider's enrollment data.

iii. Effective Date

The effective date in PECOS for the Delegated Official section of the Form CMS-20134 should be the date of signature.

iv. Social Security Number

To be a delegated official, the person must have and must submit his/her social security number. An Individual Taxpayer Identification Number (ITIN) cannot be used in lieu of an SSN in this regard.

v. Deletion of a Delegated Official

If a delegated official is being deleted, documentation verifying that the person no longer is or qualifies as a delegated official is not required. Also, the signature of the deleted official is not needed.

vi. Delegated Official Not on File

If the provider submits a change of information (e.g., change of address) and the delegated official signing the form is not on file, the contractor shall ensure that (1) the person meets the definition of a delegated official, (2) the Individual Ownership and/or Managing Control section of the Form CMS-20134 is completed for that person, and (3) an authorized official signs off on the addition of the delegated official. (NOTE: The original change request and the addition of the new official shall be treated as a single change request (i.e., one change request encompassing two different actions) for purpose of enrollment processing and reporting.)

vii. Signature on Paper Application

If the provider submits a paper Form CMS-20134 change request, the contractor may accept the signature of a delegated official in the Certification Statement or Delegated Official sections of the Form CMS-20134.

In addition, the Delegated Official's telephone number can be left blank. No further development is needed.

I. Supporting Documents

Refer to the Supporting Documents section of the CMS Form-20134 for information concerning supporting documents.

i. Supporting Documents for MDPP Preliminary recognition (Section 17)

Per 42 CFR 424.205(c)(1), MDPP preliminary recognition may include either a preliminary recognition established by CDC for the purposes of the DPRP or an MDPP interim preliminary recognition. MDPP interim preliminary recognition means a status that CMS has granted to an entity. Thus, an organization with MDPP preliminary recognition may submit supporting document – likely a notification letter of enrollment status from either CMS or CDC. Contractors shall verify supporting documents with what was submitted in the Identifying Information section of the Form CMS-20134, and any other documentations provided by CMS, including lists of organizations with MDPP interim preliminary recognition. The Contractor shall:

- Verify that any letter has appropriate letterhead from either CDC or CMS, and that the letter indicates that the organization has met preliminary recognition with an effective date within a year of the application
- Verify that the organization code on the application matches both the organization code on the letter as well as either CDC's online registry or any list provided by CMS for those with interim preliminary recognition
- Verify that the CDC's online registry or any list provided by CMS indicates that the entity associated with that organizational code has met MDPP preliminary recognition
- Verify that name associated with the organizational code on the list is consistent with the name that is listed in the supporting documentation.

ii. Supporting Documents for Full CDC Recognition

Organizations with full CDC recognition must submit a copy of its recognition certificate provided by CDC. To verify the applicant's eligibility, the Contractor shall:

- Verify that the submitted certificate reflects that the organization has met full recognition with an effective date within a year of the application
- Verify that the organization code on the Identifying Information section of the Form CMS-20134 matches both the organization code on CDC's online registry and on the certificate.
- Verify that CDC's online registry indicates that the entity associated with that organizational code has met full recognition
- Verify that name associated with the organizational code on CDC's online registry is consistent with what is listed on the certificate, as well as what is provided in the Identifying Information section of the Form CMS-20134

2. Additional Processing Information and Alternatives

a. Unsolicited Additional Information

Regarding unsolicited additional information, if the provider submits missing/clarifying data or documentation on its own volition (i.e., without being contacted by the contractor), the contractor shall include this additional data/documentation in its overall application review. Any new or changed information that a provider submits prior to the date the contractor finishes processing a previously submitted change request is no longer considered to be an update to that change request. Rather, it is considered to be and shall be processed as a separate change request. The contractor may process both changes simultaneously, but the change that was submitted first shall be processed to completion prior to the second one being processed to completion.

b. Information Disclosed Elsewhere

If a data element on the supplier's Form CMS-20134 application is missing but the information is disclosed: (1) elsewhere on the application or (2) in the supporting documentation submitted with the application, the contractor need not obtain the missing data via an updated Form CMS-20134 page and a newly-signed certification statement; no further development – not even by telephone – is required. The following information, however, must be furnished in the appropriate section(s) of the Form CMS-20134, even if the data is identified elsewhere on the form or in the supporting documentation:

- Any final adverse action data requested in the Final Adverse Legal Actions/Convictions section (Section 3) and Organizational and Individual Ownership and/or Managing Control Final Adverse Legal Action History sections (sections 5B and 6B) of the Form CMS-20134
- The applicants legal business names (LBN) or legal names
Note: If an application is submitted with a valid NPI and PTAN combination, but the LBN field is blank, an incomplete or inaccurate LBN is submitted, or the applicant includes a DBA name in MDPP Location Information section of the Form CMS-20134 and the contractor is able to confirm the correct LBN based on the NPI and PTAN combination provided, the contractor is not required to develop.
- Tax identification numbers (TIN)

Note: MACs may use the shared systems, PECOS or their provider files as a resource to determine the PTAN or NPI before developing to the provider.

If the supporting documentation currently exists in the provider's file, the provider or supplier is not required to submit that documentation again during the enrollment process. The MAC shall utilize the existing documentation for verification. Documentation submitted with a previously submitted enrollment application, or documentation currently uploaded in PECOS, qualifies as a processing alternative, unless stated otherwise in this chapter or any CMS directive. Also, per section 10.6.19(H) of this chapter, the contractor shall document in the provider file that the missing information was found elsewhere in the enrollment package. This excludes information that must be verified at the current point in time (i.e. a license without a primary source verification method). Additionally, contractors shall not utilize information submitted along with opt-out applications for enrollment application processing or vice-versa.

c. City, State, and ZIP Code

If an address (e.g., correspondence address, practice location) lacks a city, state or zip + four, the contractor can verify the missing data in any manner it chooses. In addition, the contractor can obtain the zip + four from either the U.S. Postal Service or the Delivery Point Validation in PECOS.

d. Inapplicable Questions

The supplier need not check “no” for questions that obviously do not apply to its supplier type.

10.3.3 – Other Enrollment Forms: Information and Processing **(Rev. 10524; Issued: 12-17-20; Effective: 11-13-20; Implementation: 11-13-20)**

The following forms or form types are routinely submitted with an enrollment application.

A. CMS-588 – Electronic Funds Transfer (EFT) Authorization Agreement

The Electronic Funds Transfer Agreement authorizes CMS to deposit Medicare payments directly into a provider/supplier's bank account.

1. Processing the CMS-588

When a CMS-588 Electronic Funds Transfer (EFT) form is received, the MAC shall complete the review of the form and develop for any deficiencies found on the form prior to approval.

a. Unsolicited Information

If the provider submits missing/clarifying data or documentation on its own volition (i.e., without being contacted by the contractor), the contractor shall include this additional data/documentation in its overall form review. If the form contains no changes, the contractor shall return the form to the provider or supplier.

b. Missing or Incorrect SSN or EIN checkbox on the CMS Form 588 (EFT)

If the Form CMS-588 is received and the checkbox for the Social Security Number (SSN) or Employer Identification Number (EIN) is missing or incorrect, but the contractor can ascertain the correct option via the supporting documents submitted or elsewhere on the form, the contractor may proceed without development back to the provider or supplier.

2. CMS-588 Information Specific to DMEPOS Suppliers

For CMS-855S enrollment, CMS only requires collection of Form CMS-588 with initial enrollment applications.

3. CMS-588 Signature Requirements

Valid signatures include handwritten (wet) signatures in ink and digital/electronic signatures (digital or electronic signatures such as those created by digital signature options, created in software, such as Adobe) shall be accepted. Contractors shall contact their PEOG BFL for questions regarding electronic signatures.

All signatures (handwritten or digital) are valid and appropriate in regards to (1) signatures on the paper Form CMS-588 (2) uploaded signatures on the certification statement for Internet-based Provider Enrollment, Chain and Ownership System (PECOS) forms.

4. Verification

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

- All EFT arrangements comply with CMS Publication 100-04, chapter 1, section 30.2.5.
- The information submitted on the Form CMS-588 is complete and accurate. Contractors shall develop for any missing information,

- 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 upload a signature via PECOS)
- Contractors shall forgo development if the Part I: Reason for Submission (Individual vs. Group) is left blank or an incorrect option is selected but the MAC is able to make the correct determination based on the provider's existing file or additional information submitted with the application.
- The current version of the CMS-588 indicates on page 3 that the "account to which EFT payments are made must exclusively bear the name of the physician or individual practitioner, or the legal business name of the person or entity enrolled with Medicare". Contractors shall accept accounts that solely list the LBN and accounts that list the LBN and the Doing Business As name as long as the LBN is listed first.

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 or CMS-20134.

During revalidation, contractors shall develop for the EFT form if the provider/supplier does not have the most current version of CMS-588 (EFT) on file.

If an EFT form is submitted along with a bank letter or voided check, MACs may verify that the legal name or LBN matches and develop to process the application accordingly.

5. Miscellaneous EFT Policies

a. 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.

b. 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.

c. 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.

d. 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 deactivation procedures in accordance with the instructions in this chapter. The basis for deactivation would be §424.540(a)(2) due to the provider's failure to comply with the EFT requirements outlined in §424.510(e)(1) and (e)(2).

e. 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.

f. 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, CMS-20134 or Form CMS-588 request identifying where it wants payments to be sent.

g. 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.

B. CMS-460 – Medicare Participating Physician or Supplier Agreement

This agreement establishes that the Medicare provider/supplier accepts assignment of the Medicare Part B payment for all services for which the participant is eligible to accept assignment under the Medicare law and regulations and which are furnished while the agreement

is in effect. (This only applies to suppliers that complete the Forms CMS-855B, CMS-855S, and CMS-855I.) Individual physicians and non-physician practitioners who only reassign benefits to a clinic/group practice inherit the Par status established by the clinic/group practice therefore these physicians and non-physician practitioners do not need to submit the CMS-460.

The contractor shall follow the instructions in CMS Publication 100-04, chapter 1, sections 30 through 30.3.12.3 when handling issues related to par agreements and assignment. Queries related to the interpretation of such instructions shall be referred to the responsible CMS component.

Individual physicians and non-physician practitioners who reassign benefits to a clinic/group practice inherit the Par status established by the clinic/group practice. However, if the individual physician or non-physician practitioner maintains a private practice, separate from the reassignment of benefits agreement, he/she may designate their own Par status. Refer to the instructions in Publication 100-04, chapter 1, section 30 for applying the correct Par status to clinic/group practices, organizations and individuals in private practice.

1. PECOS Information

All suppliers must choose to be either Par or Non-Par when enrolling and must maintain the same Par status across all lines of business. The MAC shall search PECOS to determine if an enrollment already exists with the enrolling provider or supplier's legal business information (i.e.: Legal Business Name, Federal Tax Identification Number).

No Par status change shall be made by the MAC without confirmation from the provider/supplier first. In the event that a provider/supplier submits a Par Agreement and they are currently enrolled as Non-Par, the MAC must confirm with the provider/supplier that the change in the Par status is valid for all lines of business. Likewise, if a provider/supplier does not submit a Par Agreement, and they are enrolled as Par or Non-Par, the MAC shall confirm that the provider or supplier is not changing their current Par status across all lines of business.

2. Valid signatures

Valid signatures include handwritten (wet) signatures in ink and digital/electronic signatures (digital or electronic signatures such as those created by digital signature options, created in software, such as Adobe) shall be accepted. Contractors shall contact their PEOG BFL for questions regarding electronic signatures.

All signatures (handwritten or digital) are valid and appropriate in regards to (1) signatures on the paper Form CMS-460 (2) uploaded signatures on the certification statement for Internet-based Provider Enrollment, Chain and Ownership System (PECOS) forms.

C. State-Specific Forms for Certified Provider/Supplier

If the applicant is a certified supplier or certified provider, it will need to contact the State agency for any State-specific forms and to begin preparations for a State survey. (This does not apply for those certified entities, such as federally qualified health centers, that do not receive a State survey.)

10.4 – Medicare Enrollment: Contractor Processing Duties (Rev. 10723; Issued: 04-08-21; Effective: 07-27-20; Implementation: 08-10-20)

A. Processing Duties – Introduction

1. Overview of Processing Duties

In general, the application review and verification process is as follows:

- a. Contractor receives application
- b. Contractor reviews application and verifies data thereon
- c. If (a) required data/documentation is missing, (b) data cannot be verified, and/or (c) there are data discrepancies, contractor requests missing/clarifying information from the provider.
- e. If applicable, contractor (a) verifies any newly furnished data, or (b) seeks additional data/clarification from provider.
- f. Certified providers and suppliers must first coordinate with Survey and Certification and the State Agency prior to rendering a final determination.
- g. Final determination

Sections 10.4(A)(2) through 10.4(F) are structured so as to generally follow Steps 10.4(A)(1)(a) through 10.4(A)(1)(f) above.

2. Processing Duties Regarding Non-CMS-855 and CMS- 20134 Enrollment Forms

There are situations where the contractor processes non-CMS-855 and CMS- 20134 forms and other documentation relating to provider enrollment. Such activities include:

- EFT agreements (Form CMS-588) submitted alone
- "Do Not Forward" issues
- Par agreements (Form CMS-460)
- Returned remittance notices
- Informational letters received from other contractors
- Diabetes self-management notices
- Verification of new billing services
- Paramedic intercept contracts
- 1099 issues that need to be resolved

- Opt-Out Affidavits

Unless specified otherwise in this chapter or another CMS directive, the contractor should not create a logging and tracking record for any non-CMS-855 or non-CMS-20134 document or activity other than the processing of par agreements, EFT Agreements, Opt-Out Affidavits, Diabetes self-management notices and paramedic intercept contracts. The contractor should track and record all other activities internally.

B. Receipt of Application(s)

1. Acknowledgment of Receipt of Application

The contractor may, but is not required to, send out acknowledgment letters or e-mails.

2. Pre-Screening of Application

The contractor is no longer required to pre-screen provider enrollment applications.

3. Reassignment Packages

In situations where an entity wants to simultaneously enroll a group practice, the individual practitioners therein, and to reassign benefits accordingly, the contractor shall adhere to the instructions contained in the scenarios below. As early in the process as possible, the contractor shall examine the incoming forms to see if a reassignment may be involved; also, the contractor is encouraged (though not required) to have the same analyst handle all three applications in the package.

Only the Form CMS-855Rs are submitted - If a brand new group with new practitioners is attempting to enroll but submits only the Form CMS-855Rs for its group members (i.e., neither the initial Form CMS-855B nor the initial Form CMS-855Is were submitted), the contractor shall develop for the other forms upon receipt and processing.

Only the Form CMS-855R is submitted and a Form CMS 855A or CMS 855B and Form CMS 855I is already on file – Suppose an individual: (1) submits only the Form CMS-855R without including the Form CMS-855A or Form CMS-855B and Form CMS-855I, and (2) indicates on the Form CMS-855R that he/she will be reassigning all or part of his/her benefits to the CAH II. The contractor shall not develop for the other forms if they are already on file. The Part A/B MAC shall simply process the Form CMS-855R and reassign it to the Form CMS-855A.

Only the Form CMS-855B is submitted - If a brand new group wants to enroll but submits only the Form CMS-855B without including the Form CMS-855Is and Form CMS-855Rs for its group members (i.e., the Form CMS-855B arrives alone, without the other forms), the contractor shall develop for the other forms if they are not submitted upon receipt and processing of the Form CMS-855B.

Only the Form CMS-855I is submitted – Suppose an individual: (1) submits only the Form CMS-855I without including the Form CMS-855B and Form CMS-855R, and (2) indicates on the Form CMS-855I that he/she will be reassigning all or part of his/her benefits to the group practice. The contractor shall develop for the other forms if they are not submitted upon receipt and processing of the Form CMS-855I.

Suppose an individual: (1) submits only the Form CMS-855I, and (2) indicates on the Form CMS-855I that he/she will be reassigning all or part of his/her benefits to an existing Part A CAH II. The contractor shall develop for the CMS-855R if it is not submitted upon receipt and processing of the Form CMS-855I. Upon receipt of the CMS-855R, the contractor shall process the application and reassign the individual to the Part A entity.

Suppose an individual is joining a group that was enrolled prior to the Form CMS-855A or Form CMS-855B (i.e., the group or CAH II never completed a Form CMS-855), the contractor shall develop for a Form CMS-855A from the CAH II or Form CMS-855B from the group. Once the group or CAH II's or group's application is received and processed, the contractor shall process the new reassignment.

C. Application Review and Verification Activities

Unless stated otherwise in this chapter or in another CMS directive. The instructions in this subsection apply to:

- The Form CMS-855A, Form CMS-855B, Form CMS-855I, Form CMS-855R, Form CMS-855O, CMS-20134, and opt-out affidavits.
- All Form CMS-855, CMS-20134 and opt-out affidavits transaction types identified in this chapter (e.g., changes of information, reassignments).

1. Application Review

Except for situations where a “processing alternative” applies (see Pub. 100-08, Chapter 15, sections 15.7.1.3 through 15.7.1.3.5), the contractor shall:

- Ensure that the provider has completed all required data elements on the Form CMS-855, CMS-20134 or Opt-Out Affidavits (including all effective dates) and that all supporting documentation has been furnished. The contractor shall also ensure that the provider has completed the application in accordance with the instructions (1) in this chapter and in all other CMS directives and (2) on the Form CMS-855 or CMS-20134. (The instructions on the Form CMS-855 or CMS-20134 shall be read and applied in addition to, and not in lieu of, the instructions in this chapter and all other applicable CMS directives.)
- Verify and validate all information furnished by the provider on the CMS-855, CMS-20134 or Opt-Out Affidavits, provided that a data source is available.
- Coordinate with State survey/certification agencies and regional offices (ROs), as needed.
- Upon initial enrollment, revalidation, changes of information adding a new individual to the enrollment record and opt-out affidavits, confirm and document that the applicant, all individuals and entities listed on the application, and any names or entities ascertained through other sources, are not presently excluded from the Medicare program by the HHS Office of the Inspector General (OIG) or through the System for Award Management.

The instructions in sections 10.4(C)(1) through 10.4(F) are in addition to, and not in lieu of, all other instructions in this chapter.

2. Review of Paper Applications

a. General Background Information

The contractor shall begin processing the application upon receipt and shall develop for missing certification statements and all other missing information, including application fee, upon review. This includes, but is not limited to (and subject to the processing alternatives (see Pub. 100-08, Chapter 15, sections 15.7.1.3 through 15.7.1.3.5)):

- Ensuring that all required data elements on the application have been completed and that all required supporting documentation has been submitted
- Submitted a valid and dated certification statement signed by an appropriate individual (e.g., the enrolling physician for Form CMS-855I applications)
- Validating all data on and submitted with the application, provided that a data source is available
- Entering all information contained on the application into the Provider Enrollment, Chain and Ownership System (PECOS).

The contractor may begin the verification process at any time. Also, the contractor is not required to create a PECOS logging and tracking (L & T) record within a certain specified timeframe (e.g., within 20 days after receipt of the application).

b. Other Guidelines

i. Reenrollment Bar

If the contractor suspects that a provider or supplier is attempting to circumvent an existing reenrollment bar by enrolling under a different business identity or as a different business type, the contractor shall contact their CMS' Provider Enrollment & Oversight Group Business Function Lead (PEOG BFL) for guidance.

ii. State and Country of Birth

The state of birth and country of birth are optional data elements on the Form CMS-855 and CMS-20134. As such, the contractor shall not develop for this information if it was not disclosed on the application and shall not request other contractors to update the PECOS Associate Control (PAC) ID to include this data.

iii. Photocopying Pages

The contractor may accept photocopied pages in any Form CMS-855 or CMS-20134 it receives so long as the application contains a valid signature. For example, suppose a corporation wants to enroll five medical clinics it owns. The section 5 data on the Form CMS-855B is exactly the same for all five clinics. The contractor may accept photocopied section 5 pages for these providers. However, valid signatures must be furnished in section 15 of each application.

iv. White-Out & Highlighting

The contractor shall not write on or highlight any part of the original Form CMS-855 or CMS-20134 application or any supplementary pages the applicant submits (e.g., copy of license). Provider usage of white-out is acceptable, although the contractor should contact the applicant to resolve any ambiguities. In addition, the contractor must determine whether the amount of white-out used on a particular application is within reason. For instance, if an entire application page is whited-out, the contractor should request that the page be resubmitted

3. Review and Processing of Internet-based PECOS Applications

a. General Background Information

This section furnishes guidance to contractors on the proper handling and processing of Form CMS-855 or CMS-20134 applications submitted via the Internet (hereinafter referred to as "Internet-based PECOS" applications). Unless otherwise stated:

- The instructions in this section 10.4(C)(3) apply only to Internet-based PECOS applications.
- The instructions in sections 10.4(C)(1) through 10.4(F) of this chapter take precedence over those in this section 10.4(C)(3).

The principal logging and tracking (L & T) statuses for PECOS Internet applications that are not in a final status are:

- Received;
- In Review;
- Returned for Corrections;
- Corrections Received;
- Review Complete; and
- Application in Process.

The submission of a PECOS Internet application will immediately place the L & T record into a "Received" status.

b. Certification Statement Pertaining to Application Submitted More Than 60 Days Prior to the Effective Date

If the contractor can determine (without having yet begun processing the application) that an application can be returned under section 10.4(H)(1) of this chapter (e.g., Form CMS-855I was submitted more than 60 days prior to the effective date), the contractor may return the application without waiting for the arrival of the certification statement.

c. Certification Statement Submitted On Paper or Through E-Signature

Providers and suppliers shall submit an e-signature or submit a certification statement via PECOS upload functionality. No paper certification statements shall be submitted by mail, fax, or scanned e-mail, unless stated otherwise in this chapter or in another CMS directive.

The contractor shall begin processing the application upon receipt and shall develop for missing certification statements and all other missing information, including application

fee, upon review. Contractors shall refer to Section 10.4(H)(2) of this manual regarding rejection of an application for non-submission of development.

- If the provider submits an invalid certification statement (e.g., incorrect individual signed it; not all authorized officials signed it), the contractor shall treat this as missing information and shall develop for a correct certification statement using – unless another CMS directive states otherwise - the procedures outlined in this chapter.

i. Certification Statement for Initial PECOS Internet Applications

For initial PECOS Internet applications (as the term “initial” is defined in Pub. 100-08, Chapter 15, Section 15.6), it is only necessary that the dated signature of at least one of the provider’s authorized officials be on the certification statement.

ii. Certification Statement for Change of Information Applications Submitted Via Internet – Based PECOS

For Internet-based PECOS changes of information (as the term “changes of information” is defined in Pub. 100-08, Chapter 15, Section 15.6), if the certification statement is signed by an individual who is not on file with the contractor as being an authorized or delegated official of the provider, the contractor may accept the certification statement but shall develop for information on the person in question in accordance with Pub. 100-08, Chapter 15, sections 15.7.1.3 through 15.7.1.3.5.

d. Switch to “In Review” and Application Returns

After – and only after - it receives and accepts the provider’s certification statement, the contractor shall: (1) enter the date of the signature into the “Certification Date” box in the L & T record, and (2) change the L & T status to “Review Complete.” The contractor shall begin processing the application upon receipt and shall develop for missing certification statements and all other missing information, including application fee, upon review.

After changing the L & T status to “In Review,” the contractor shall review the Application Data Report (ADR), and shall commence all applicable validation activities identified in this chapter. (The ADR is only available for printing when the L & T record is in one of the following statuses: “In Review,” “Returned for Corrections,” or “Corrections Received.”)

e. Transferral of Data into PECOS

Once the contractor ties the L & T record to the enrollment record, the contractor shall begin the process of transferring the data into PECOS by accepting or rejecting the various data elements. The contractor shall note that: (1) it cannot undo any transfer of information into PECOS, and (2) once the L & T is tied to the enrollment record, the application cannot be returned to the provider for corrections.

f. Miscellaneous Instructions

NOTE: The contractor is advised of the following:

- **Deletion of Erroneous Record** - The contractor shall only delete an erroneously created L & T record by: (1) moving the L & T record to a status of “Rejected,” and (2) using an L & T status reason of “Deleted.”
- **Gatekeeper/Enrollment Screens** - The Gatekeeper and Enrollment screens are only used in the case of Form CMS-855 or CMS-20134 initial enrollment PECOS Internet submissions.
- **Post-Processing Recordkeeping** - After processing a particular PECOS Internet transaction, the contractor shall maintain in the provider’s file: (1) a copy of the final version of the ADR, (2) all submitted certification statements and applicable supporting documents, and (3) documentation of all contacts with the provider (e.g., phone calls, e-mails) per section 10.6.19(H) of this chapter.
- **State Agencies** - In situations described in this chapter in which the contractor is required to submit a copy of the provider’s paper Form CMS-855 to the state agency, the contractor shall send a copy of the ADR in lieu of the Form CMS-855 if the provider sent in its application via the Internet.

4. Verification - General

a. Means of Verification

Unless stated otherwise in this chapter or in another CMS directive, the contractor shall verify and validate – via the most cost-effective methods available - all information furnished by the provider on or with its application, provided a data source is available. The general purpose of the verification process is to ensure that all of the data furnished on the Form CMS-855 or CMS-20134 is accurate.

Examples of verification techniques include, but are not limited to:

- Site visits
- Third-party data validation sources
- State professional licensure and certification Web sites (e.g., medical board sites)
- Federal licensure and certification Web sites (if applicable)
- State business Web sites (e.g., to validate “doing business as” name)
- Yellow Pages (e.g., to verify certain phone numbers)

The list of verification techniques identified in this section 10.4(C) is not exhaustive. If the contractor is aware of another means of validation that is as cost-effective and accurate as those listed, it is free to use such means. However, all Social Security Numbers (SSNs) and National Provider Identifiers (NPIs) listed on the application will continue to be verified through PECOS. The contractor shall not request an SSN card or driver’s license to verify an individual’s identity or SSN.

b. Procedures

Unless stated otherwise in this chapter or in another CMS directive, the following principles apply:

- (1) A data element is considered “verified” when, after attempting at least one means of validation, the contractor is confident that the data is accurate. (The contractor shall use its best judgment when making this assessment.)
- (2) The contractor need only make one verification attempt (i.e., need only use one validation technique) before either:
 - (a) Requesting clarifying information (as described in sections 10.4(D) through 10.4(F)) if the data element cannot be verified. (However, the contractor is encouraged to make a second attempt using a different validation means prior to requesting clarification.)

OR

- (b) Concluding that the furnished data is accurate.

c. Concurrent Reviews

If the contractor receives multiple Form CMS-855 or CMS-20134s for related entities, it can perform concurrent reviews of similar data. For instance, suppose a chain home office submits initial Form CMS-855As for four of its chain providers. The ownership information (sections 5 and 6) and chain home office data (section 7) is the same for all four providers. The contractor need only verify the ownership and home office data once; it need not do it four times – once for each provider. However, the contractor shall document in each provider’s file that a single verification check was made for all four applications.

For purposes of this requirement: (1) there must be an organizational, employment, or other business relationship between the entities, and (2) the applications must have been submitted within a few weeks of each other. As an illustration, assume that Group Practice A submits an initial Form CMS-855B on January 1. Group Practice B submits one on October 1. Section 6 indicates that Joe Smith is a co-owner of both practices, though both entities have many other owners that are not similar. In this case, the contractor must verify Mr. Smith’s data in both January and October. It cannot use the January verification and apply it to Group B’s application because: (1) the applications were submitted nine months apart, and (2) there is no evidence that the entities are related.

d. Contacting Other Contractor

During the verification process, the contractor may need to contact another Medicare contractor for information regarding the provider. The latter contractor shall respond to the former contractor’s request within three business days absent extenuating circumstances.

5. Verification Processing Alternatives

Special processing rules (“processing alternatives”), found in Pub. 100-08, Chapter 15, Sections 15.7.1.3 through 15.7.1.3.5 are intended to reduce the burden on contractors and

providers while simultaneously maintaining the integrity of the enrollment process. These provisions take precedence over all other instructions outlined in this chapter 10.

Proof of Life Documentation

In the event an enrollment record is updated to reflect an erroneous date or report of death, the contractor shall request documentation that supports “proof of life” (e.g., Retirement, Survivors, and Disability Insurance document issued by SSA). In the event a provider/supplier is unable to obtain such documentation, the contractor shall submit a request to their Provider Enrollment Oversight Group (PEOG) Business Function Lead (BFL) containing the provider/supplier’s name, date of birth and SSN so that CMS can confirm proof of life with SSA.

D. Requesting Missing/Clarifying Data/Documentation (Development)

The procedures in sections 10.4(D) are subject to the processing alternatives found in Pub. 100-08, Chapter 15, Sections 15.7.1.3 through 15.7.1.3.5.

1. Development Requests

When requesting missing/clarifying information/documentation and/or or requesting a valid certification statement, the contractor shall adhere to the following:

2. Only One Request Needed

This is the only request the contractor must make. The contractor should, of course, respond to any of the provider’s telephone calls, e-mails, etc., resulting from the request. Yet the contractor need not – on its own volition – make an additional request unless the contractor uncovers missing data (or data that must be clarified) that it failed to detect prior to sending the original development letter.

To the extent possible, the contractor should avoid contacting the provider for missing/clarifying data/documentation until it has attempted to validate all of the data on the application. This will obviate the need to contact the provider each time the contractor discovers an issue.

3. Commencement of Timeframe

The 30-day clock referred to above commences on the day on which the contractor, as applicable: (1) mails, faxes, or e-mails the letter/request, or (2) sends the aforementioned Internet-based PECOS e-mail.

4. Telephonic Requests

Unless otherwise stated in this chapter or in another CMS directive, telephonic requests for missing/clarifying data/documentation are generally not permitted for paper or Internet-based PECOS applications; it is important that requests for information or clarification be formalized in writing. However, in cases where CMS permits telephonic requests for such data, the contractor shall adhere to the following:

- A telephonic request is made when the contractor: (1) speaks with an appropriate provider official, or (2) leaves a message either with an appropriate official’s staff (e.g., his/her

executive assistant) or with an appropriate official's voice mail service. In situation (2), the contractor shall leave the name and telephone number of an appropriate individual at the contractor site who the official can contact; otherwise, the contact does not qualify as a legitimate request for clarification.

- When leaving a message, the contractor shall also state that the requested data/clarification must be furnished within 30 days.
- Telephone requests shall be made on weekdays between 9 am and 5 pm of the provider's time zone.
- The 30-day clock begins on the day (1) of the telephone conversation with the appropriate official, or (2) the message is left.

5. Inability to Contact Provider

If the contractor cannot, for the reasons listed below, communicate with the provider to request information/documentation, it shall attempt one alternative means of communication:

- The mailed letter is returned because the provider is not at that address
- The contractor cannot e-mail the letter to the provider because of issues with the recipient's e-mail system.
- The provider's fax number is repeatedly busy

If an alternative communication also cannot be completed for one of the above reasons, the contractor need not make another attempt to obtain the data and may reject the application once the applicable 30-day period expires. However, it is strongly advised that the contractor make a third attempt to contact the provider prior to taking this step, especially if it appears that the provider is otherwise acting in good faith. (The contractor shall document each attempt to contact the provider.)

(With respect to e-mail, an alternative communication includes sending an e-mail to another listed contact person, delegated official, or authorized official.)

6. Development: Paper Applications

a. Reasons to Develop: Paper Applications

Development is necessary if the provider or supplier:

- Submits an application with at least one missing required data element
- Fails to submit at least one required document
- Submits an invalid certification statement, or
- Writes "N/A" (or a variation thereof) in response to a question that requires a "yes" or "no" answer
- The full application was submitted via fax or email unless the contractor has provided for an exception based on extenuating circumstances

Note: should the contractor instruct the provider/supplier to submit their application via fax or email, the contractor shall inform their PEOG BFL.

Further, development is necessary if the contractor determines that clarification is needed regarding certain information (e.g., particular data cannot be verified or there are data inconsistencies).

b. Elements of a Development Letter

If any of the development reasons above apply, the contractor shall send a development letter to the provider – preferably via e-mail or fax - that contains, at a minimum, the applicable elements in (i) through (vi) below. (See Section 10.7 of this chapter for these model letters)

- i. A list of all of the missing required data/documentation, an explanation of the certification statement's deficiencies, and/or the issues/information to be clarified.
- ii. A request that the provider submits the missing data/documentation, clarification, and/or revised certification statement within 30 calendar days.
- iii. Unless the only data that is missing is documentation, a request that the provider submit an appropriately signed and dated certification statement, which will cover both the submission of any missing data as well as any deficiencies associated with the original certification statement. The certification statement may be submitted by the provider via scanned email, fax or mail (paper submissions only).

(A new certification statement is not required if the only missing material is documentation or if the clarification to be provided does not require any changes to the provider's Form CMS-855 or CMS-20134 application.)

- iv. If missing data is involved, the MAC shall direct the provider or supplier to the CMS Web site at which the CMS-855 or CMS-20134 forms can be found.
- v. A fax number and mailing address to which the missing/clarifying data/documentation/correct certification statement can be sent to the contractor. An email address may be included if applicable.
- vi. The name and phone number of a contact person at the contractor site. An email address may be included if applicable.

7. Development: Internet-Based PECOS Applications

a. Reasons to Develop: Internet-Based PECOS Applications

Development is necessary if the provider or supplier:

- Submits an application with at least one missing required data element
- Fails to submit at least one required document
- Submits an invalid certification statement, or
- Enter "N/A" (or a variation thereof) in response to a question that requires an answer

b. Elements of a Development Request

The contractor may – after switching the L & T status to “Returned for Corrections” - send an e-mail (via PECOS).

When developing for more information, after switching the L & T status to “Returned for Corrections,” the contractor shall send a request to the provider or supplier and may send an email via PECOS containing:

- (i) A list of all missing data/documentation, information to be clarified, and/or certification statement issues;
- (ii) A request that the provider submit the data/materials in question within 30 calendar days; and
- (iii) The name and phone number (an e-mail address is optional) of a contact person at the contractor site.

The contractor shall not attempt to contact the provider for the missing/clarified information and/or valid certification statement prior to sending the e-mail referenced above, though the contractor is free to make a follow-up contact with the provider after sending the e-mail.

E. Receiving Missing/Clarifying Data/Documentation (Response to Development)

The procedures in this section 10.4(E) are subject to the processing alternatives found in Pub. 100-08, Chapter 15, sections 15.7.1.3 through 15.7.1.3.5.

1. Requirement to Furnish All Missing/Clarifying Material

The provider must furnish all missing/clarifying data/documentation requested by the contractor within the 30-day timeframe. Whether the provider furnished all the information is a decision resting solely with the contractor. Should the provider furnish some (but not all) of the requested data/clarification within the specified time period, the contractor need not contact the provider again to request the remaining information. For instance, suppose the contractor requested missing data in sections 3, 4, and 5 of the Form CMS-855A. The provider only furnished the section 3 data. The contractor may reject the application without attempting another contact.

2. Format of Furnishing Missing Data

a. Paper Applications

Unless stated otherwise in this chapter or in another CMS directive, the provider shall: (1) provide the missing/clarification information (excluding documentation) on the applicable Form CMS-855 or CMS-20134 page(s) and (2) submit the missing material via mail, fax, or scanned e-mail. A newly signed and dated certification statement must accompany the Form CMS-855 or CMS-20134 page(s) containing the missing data – unless the only missing information is supporting documentation, in which case no new certification statement is needed. The certification statement may be submitted by the provider via scanned email, fax or mail (paper submissions) along with the missing information.

b. Internet-Based PECOS Applications

Unless stated otherwise in this chapter or in another CMS directive, the provider may (1) submit the missing information by entering it into PECOS, (2) submit the missing documentation via fax, e-mail, mail, or the Digital Data Repository (DDR). (The provider may submit the missing data via the applicable paper Form CMS-855 or CMS-20134 pages if it submitted its application via Internet-based PECOS.) The certification statement may be submitted by the provider via scanned email, fax, upload or e-signature along with the missing information.

3. Format of Clarifying Data

In cases where clarifying (as opposed to missing) information is requested, the contractor may accept the clarification by e-mail, fax, or letter. If the provider furnishes the clarification via telephone, the contractor shall – unless another CMS directive states otherwise - request that the provider furnish said clarification in writing (preferably via e-mail).

If the provided clarification ultimately requires the provider to change or alter data that must be reported on the paper CMS-855 or CMS-20134 or PECOS application, the contractor shall instruct the provider via a follow-up e-mail or fax to submit the revised data on the applicable paper CMS-855 or CMS-20134 or PECOS application and to furnish a new certification statement. The provider must submit the revised data and new certification statement within 30 days of the original request for clarification (rather than 30 days from the date of the follow-up request to provide the data via the Form CMS-855 or CMS-20134). The certification statement may be submitted by the provider via scanned email, fax, upload, e-signature or mail (paper submissions) along with the missing information.

Consider the following illustrations:

EXAMPLE 1: The contractor notifies the provider via an e-mailed letter on March 1 of a discrepancy regarding its ownership information on the Form CMS-855A. The provider e-mails the contractor on March 3 and explains the discrepancy. Based on this e-mail, the contractor determines that the provider must correct its ownership data in section 5 of its Form CMS-855A. The contractor sends a follow-up e-mail to the provider on March 7 instructing the provider to do so. The provider must submit the revised data on the Form CMS-855 or CMS-20134 (with a new certification statement) by March 31 (not April 6, or 30 days from the date of the follow-up e-mail).

EXAMPLE 2: The contractor notifies the provider via e-mailed letter on March 1 of a discrepancy regarding its ownership information on the Form CMS-855A. The provider telephones the contractor on March 6 and explains the discrepancy to the contractor's satisfaction. Although the discrepancy does not require the provider to make any revisions to its Form CMS-855A, the contractor shall request that the provider furnish its explanation in writing no later than 30 days from its March 1 e-mail (or March 31), not 30 days from the date of its March 6 request for the written explanation.

EXAMPLE 3: The contractor notifies the provider via e-mailed letter on March 1 of a discrepancy regarding its ownership information on its paper Form CMS-855A. Determining (based on the contractor's e-mail) that the ownership information it provided was incorrect, it submits a revised section 5 of its Form CMS-855A to the contractor with a new certification statement but without any accompanying explanation of the change (e.g., no accompanying letter or e-mail). The contractor receives the revised section 5 on March 12. If the contractor determines that the discrepancy has been resolved via the revised submission, it is not

required to contact the provider for an accompanying written explanation. (This is because the clarification was furnished in writing via the CMS-855 or CMS-20134 itself.) If, however, the contractor would like a written explanation or otherwise needs clarification about the submission, it may request that a written explanation be submitted no later than March 31.

4. Maintenance of Received Material

The contractor shall maintain all missing/clarifying information or documentation received (including new certification statements) in the provider file. Storage can be electronic or via hard copy, but it must be in an otherwise easily accessible format.

F. Provider or Supplier Fails to Submit Requested Data/Documentation

The instructions in this section:

- Apply unless another CMS directive or instruction states otherwise.

Are subject to the processing alternatives found in Pub. 100-08, Chapter 15, Sections 15.7.1.3 through 15.7.1.3.5.

If, in the contractor's view, the provider failed to submit all of the requested data/documentation and/or a valid certification statement (either as a correction to the original certification statement or as part of a request for missing data), the contractor may:

- Reject the application if the 30-day period has elapsed,
- Wait until the 30-day period has elapsed and then reject the application, or
- Extend the 30-day period no more than an additional 30 days if (1) it appears that the provider is making a good-faith effort to comply with the development letter and/or (2) the provider furnished most of the requested data. For instance, suppose the contractor requested 5 pieces of missing information. The provider or supplier timely submitted 4 of them and furnished a signed (though undated) certification statement. Since the provider appears to be acting in good faith, the contractor is encouraged to continue working with the provider.

If the provider fails to fully respond to a second request, the contractor may either: (1) reject the application if the original 30-day period has elapsed, (2) wait until the 30-day period has elapsed and then reject the application, or (3) make a third request using the procedures described above.

G. Application Approvals

1. Non-Certified Suppliers and Individual Practitioners

(This section does not apply to ambulatory surgical centers, portable x-ray suppliers, or providers and suppliers that complete the Form CMS-855A.)

If the contractor approves a supplier's enrollment, it shall notify the applicant via letter of the approval. The letter shall follow the content and format of the model letter in Pub. 100-08, Chapter 15, Section 15.24.1, et seq.

Absent a CMS instruction or directive to the contrary, the contractor shall send the approval letter via e-mail, mail or fax within 5 business days of approving the enrollment application in PECOS (this timeframe should allow for updating of the enrollment information in the Shared Systems (MCS, FISS or VMS)). For all applications other than the Form CMS-855S, the letter shall be sent to the supplier's contact person if one is listed; otherwise, the contractor may send the letter to the supplier at the supplier's correspondence address or special payment address.

2. Certified Providers and Certified Suppliers

(This section only applies to: (1) initial Form CMS-855A applications or change of ownership (CHOW), acquisition/merger, or consolidation applications submitted by the new owner; and (2) initial ambulatory surgical center and portable x-ray supplier applications.)

If the contractor decides to recommend approval of the provider or supplier's application, the contractor shall send a recommendation letter to the applicable State agency, with a copy to the Regional Office's (RO) survey and certification unit. (For those provider/supplier types that do not require a State survey, such as federally qualified health centers, the letter can be sent directly to the RO.) The recommendation letter shall, at a minimum, contain the following information:

- Supplier/Provider NPI Number
- CMS Certification Number (if available)
- Type of enrollment transaction (CHOW, initial enrollment, branch addition, etc.)
- Contractor number
- Contractor contact name
- Contractor contact phone number
- Date application recommended for approval (and, for FQHCs, the date that the package is complete)
- An explanation of any special circumstances, findings, or other information that either the State or the RO should know about.
- Any other information that, under this chapter 10, must be included in the recommendation letter.

The letter can be sent to the State/RO via mail, fax, or e-mail.

The contractor shall also:

- Send either a photocopy (not the original), faxed version, or e-mail version of the final completed Form CMS-855 to the State agency or RO (as applicable), along with all updated Form CMS-855 pages, explanatory data, documentation, correspondence, final sales agreements, etc. (which can also be sent via mail, fax, or e-mail). If the CMS-855,

associated documentation, and recommendation letter are mailed, they should be included in the same package.

The contractor shall not send a copy of the Form CMS-855 to the RO unless the latter specifically requests it or if the transaction in question is one for which State involvement is unnecessary.

- Notify the applicant that the contractor has completed its initial review of the application. The notification can be furnished via e-mail, or via the letter identified in Pub. 100-08, Chapter 15, Section 15.24.6, et seq. (which may be sent to the applicant's contact person), and shall advise the applicant of the next steps in the enrollment process (e.g., site visit, survey). The contractor may, but is not required to, send a copy of its recommendation letter to the provider as a means of satisfying this requirement. However, the contractor should not send a copy to the provider if the recommendation letter contains sensitive information.
- Inform initial applicants (including new owners that have rejected assignment of the provider's or supplier's provider agreement) that Medicare billing privileges will not begin before the date the survey and certification process has been completed and all Federal requirements have been met.
- Notify the applicant of the phone numbers and e-mail addresses of the applicable State agency and RO that will be handling the survey and certification process; the applicant shall also be instructed that all questions related to this process shall be directed to the State agency and/or RO.

3. Suppliers of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)

As stated in 42 CFR §424.57(b), a DMEPOS supplier must, among other things, meet the following conditions to be eligible to receive payment for a Medicare-covered item:

- The supplier has submitted a complete Form CMS-855S, including all supporting documentation, to the National Supplier Clearinghouse (NSC); and
- The item was furnished on or after the date the NSC issued to the supplier a DMEPOS supplier number conveying Medicare billing privileges.
- The date identified in the previous bullet represents the "date of approval."

4. Medicare Diabetes Prevention Program (MDPP) Suppliers

As stated in 42 CFR §424.205(d), an MDPP supplier must, among other things, not have an ineligible coach on its roster. Though the MDPP supplier's effective date for billing privileges is the date a successful Form CMS-20134 application was submitted, the contractor must notify MDPP suppliers of their application approval, as some MDPP suppliers may not begin furnishing services until receiving such information.

If the contractor approves a supplier's enrollment, it shall notify the applicant via letter of the approval. The letter shall:

- Follow the content and format of the model letter in Pub. 100-08, Chapter 15, Section 15.24.7;
- Include the National Provider Identifier (NPI) with which the supplier will bill Medicare and the Provider Transaction Access Number (PTAN) that has been assigned to the supplier as an identifier for inquiries.
- Provide instructions on how suppliers should use the assigned PTAN when they use the contractor interactive voice response (IVR) system for inquiries concerning claims status, beneficiary eligibility, check status or other supplier-related IVR transactions.
- Include language reminding suppliers to update their NPPES record whenever their information changes.

Absent a CMS instruction or directive to the contrary, the contractor shall send the approval letter within 5 business days of approving the enrollment application in PECOS. The letter shall be sent to the supplier's contact person if one is listed; otherwise, the contractor may send the letter to the supplier at the supplier's correspondence address or special payment address.

For claims submitted by MDPP suppliers prior to the date of enrollment, the contractor shall follow the instructions in Pub. 100-04, chapter 1, section 70, with respect to the claim filing limit. Payments cannot be made for services furnished prior to the date the applicant submitted an application or CAP that resulted in being successfully enrolled.

5. Additional Copies of Approval Letters

With the exception of CMS-855S applications, if any contact person listed on a provider or supplier's enrollment record, requests a copy of a provider or supplier's Medicare approval letter, the contractor shall send to the contact person via email, fax or mail. This excludes Certification Letters (Tie In notices), as the contractor is not responsible for generating these approvals.

For CMS-855S application approval letters, suppliers may visit https://www4.palmettogba.com/pgx_palmettogbacom/initStatusLetter.do and provide the requested information to receive a copy of the supplier's approval letter.

H. Application Returns, Rejections and Denials

1. Returns

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 or CMS-20134 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 PXRSS, 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, or
 - The provider or supplier submitted an initial application prior to the expiration of a re-application bar.
- 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 Pub. 100-08, Chapter 15, Section 15.7.7.1.4.
- 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 or eligible practitioner 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 provider or supplier submitted a revalidation application more than seven months prior to their revalidation due date.
- The MDPP supplier submitted an application with a coach start date more than 30 days in the future.
- A provider or supplier requests that their application be withdrawn prior to or during processing.

- A provider or supplier submits an application that is an exact duplicate of an application that has been processed previously or one that is currently pending processing.
- A provider or supplier submits a paper Form CMS-855 or CMS-20134 application that is outdated (i.e.: a provider submits a Form CMS-855I application that was approved for use in 07/11, which was replaced with the 12/18 version, the 07/11 version shall be returned).
- A rebuttal decision has been issued, therefore the submitted Form CMS-855 or CMS-20134 is not needed.

The contractor shall return the application per the instructions in section 10.4(H)(1) of this chapter.

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-submission.

b. Procedures for Returning the Application

If the contractor returns the application:

It shall notify the provider via letter (sent by mail or, as an option, 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.)

If the contractor returns an application, it shall:

- Keep the original application and supporting documents and return a copy,
- Make a copy or scan of the application and documents and return the originals to the provider, or
- Simply send a letter to the provider (in lieu of sending the originals or a copy thereof) explaining that the application is being returned (though not physically returned) and why. If the contractor chooses the third approach and the provider requests a copy of its application, the contractor should fax or mail it to the provider.

c. Other Impacts of a Return

i. 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 10.4(H)(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 CMS Provider Enrollment & Oversight 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 10.4(H)(1)(c)(i)(1) 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 10.4(H)(1)(c)(i)(2), the provider resubmits the change of information or CHOW application and the contractor either returns it again, rejects it per section 10.4(H)(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.

ii. Reactivations

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

iii. Revalidations

If the contractor returns a revalidation application per this section 10.4(H)(1), the contractor shall – unless an existing CMS instruction or directive dictates otherwise - deactivate the provider's Medicare billing privileges under 42 CFR §424.540(a)(3) 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 10.4(H)(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.

2. Rejections

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:

- (i) The Form CMS-855, CMS-20134 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; or (f) certification statement is missing (paper submission only).
- (ii) The applicant failed to submit all of the forms needed to process a reassignment package within 30 calendar days of receipt.
- (iii) The Form CMS-855 or CMS-20134 was completed in pencil.
- (iv) The wrong application was submitted (e.g., a Form CMS-855B was submitted for Part A enrollment).
- (v) 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.
- (vi) The provider failed to submit an application fee (if applicable to the situation).

The applications described in (i) through (vi) 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 development letter or other request for information to the provider. If the contractor makes a follow-up request for information, the 30-day clock does not start anew; rather, it keeps running from the date the development letter was sent. However, the contractor has the discretion to extend the 30-day 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 example:

- 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 an application with the Final Adverse Action History question completed. However, the report of each adverse action, date, taken by and resolution portion remains blank. The contractor need not make a second request for the reporting section to be completed. It can reject the application on March 31, or 30 days after its initial request was made.

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

i. 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 10.4(H)(2)(e)(i) 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 10.4(H)(2)(e)(i) of this chapter, or denies it, the contractor shall send the e-mail referred to in section 10.4(H)(2)(e)(i) 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.

ii. Reactivations

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

iii. Revalidations

If the contractor rejects a revalidation application per this section 10.4(H)(2)(e)(iii), the contractor shall – unless an existing CMS instruction or directive dictates otherwise - deactivate the provider’s Medicare billing privileges under 42 CFR §424.540(a)(3) 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 10.4(H)(2)(e)(iii) 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

i. Resubmission after Rejection

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

ii. Applicability

Unless stated otherwise in this chapter or in another CMS directive, this section 10.4(H)(1) applies to all applications identified in this chapter (e.g., initial applications, change requests, Form CMS-855O applications, and Form CMS-588 submissions, change of ownership (CHOW) applications, revalidations, and reactivations).

iii. Physicians and Non-Physician Practitioners

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

iv. Notice

If the contractor rejects an application, it shall notify the provider via letter (sent via fax, 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.

v. 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.

3. Denials

a. Notification Letters for Denials

i. General Requirements

If a Medicare contractor finds a legal basis for denying an application - and, if applicable under section 10.4(H)(3) of this chapter, receives approval from the Provider Enrollment &

Oversight Group (PEOG) for said denial - the contractor shall deny the application and notify the provider or supplier by letter. The denial letter shall contain:

- A legal (i.e., regulatory) basis for each reason for the denial;
- A clear explanation of why the application is being denied, including the facts or evidence that the contractor used in making its determination;
- An explanation of why the provider or supplier does not meet the applicable enrollment criteria;
- Procedures for submitting a corrective action plan (CAP, for denials based on 42 CFR §424.530(a)(1)); and
- Complete and accurate information about the provider or supplier's further appeal rights.

ii. Prior PEOG Approval Necessary

For cases involving 42 CFR §424.530(a)(3) (Felony Convictions), §424.530(a)(4) (False or Misleading Information or Application), 42 CFR §424.530(a)(6) (Existing Overpayment at Time of Application), 42 CFR §424.530(a)(12) (Revoked Under Different Name, Numerical Identifier, or Business Identity), 42 CFR §424.530(a)(13) (Affiliation that Poses an Undue Risk), 42 CFR §424.530(a)(14) (Other Program Termination or Suspension) or denials involving MDPP Suppliers, the contractor shall obtain approval of both the denial and the denial letter from PEOG via the ProviderEnrollmentRevocations@cms.hhs.gov mailbox prior to sending the denial letter.

Consistent with §424.530(f), CMS may apply a reapplication bar that prohibits a provider or supplier from enrolling in Medicare for up to 3 years if its enrollment application is denied because the provider or supplier submitted false or misleading information on or with (or omitted information from) its application. PEOG will notify the contractor of its determinations and instruct the contractor as to how to proceed. Absent a CMS instruction or directive to the contrary, the letter shall be sent to the provider or supplier, via certified mail, no later than 5 business days after PEOG concludes that the provider or supplier's application should be denied.

Contractors shall not proceed with finalization of a denial until guidance is received from PEOG. If guidance from PEOG is delayed, contractors shall carve the impacted application(s) out of their timeliness reporting. Contractors shall document and report the impact application in their Monthly Status Reports.

iii. Prior PEOG Approval Unnecessary

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 Pub. 100-08, Chapter 15, Section 15.24.8, et seq. Absent a CMS instruction or directive to the contrary, the letter shall be sent to the provider or supplier, via certified mail, no later than 5 business days after the contractor concludes that the provider or supplier's application should be denied.

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

iv. Denial Based Upon Reason Under 42 CFR 424.530

When issuing a denial, the contractor shall insert the appropriate regulatory basis (e.g., 42 CFR § 424.530(a)(1)) into its denial letter. The contractor shall not use provisions from this chapter 10 as the basis for denial. Except as described in section 10.4(H)(3) of this chapter or as otherwise stated in this chapter, the contractor may issue a denial letter without prior approval from CMS' Provider Enrollment & Oversight Group (PEOG) of the denial or the denial letter.

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/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.

All denied applications and all applicable denial reasons shall be entered into the Provider Enrollment Chain and Ownership System (PECOS) including fingerprint and non-covered provider or supplier type denials. For non-covered provider or supplier type denials, contractors shall select the "Other" specialty/provider/supplier type option and input the type listed on the application.

v. Denial Reasons

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

The provider or supplier is determined not to be in compliance with the enrollment requirements in subpart P (of Part 424) or on the enrollment application applicable to its provider or supplier type, and has not submitted a plan of corrective action as outlined in 42 CFR part 488. Such non-compliance includes, but is not limited to, the following situations:

- i. The provider or supplier does not have a physical business address or mobile unit where services can be rendered.
- ii. The provider or supplier does not have a place where patient records are stored to determine the amounts due such provider or other person.
- iii. The provider or supplier is not appropriately licensed.
- iv. The provider or supplier is not authorized by the federal/state/local government to perform the services that it intends to render.
- v. The provider or supplier does not meet CMS regulatory requirements for the specialty that it seeks to enroll as. (See section 10.2.7 of this chapter for examples of suppliers that are not eligible to participate.)
- vi. The provider or supplier does not have a valid social security number (SSN) or employer identification number (EIN) for itself, an owner, partner, managing

organization/employee, officer, director, medical director, and/or authorized or delegated official.

vii. The applicant does not qualify as a provider of services or a supplier of medical and health services. (For instance, the applicant is not recognized by any Federal statute as a Medicare provider or supplier (see section 10.2.7 of this chapter)) An entity seeking Medicare payment must be able to receive reassigned benefits from physicians in accordance with the Medicare reassignment provisions in § 1842(b)(6) of the Act (42 U.S.C. 1395u(b)).

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

ix. The provider or supplier does not meet standards specific to their supplier type (e.g., MDPP Supplier standards outlined in 42 CFR §424.205(d)).

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

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

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

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 or CMS-20134 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.

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

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

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

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

While, as discussed in section 10.4(M)(2)(c) of this chapter, a re-enrollment bar will be established 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.

Note that if an MDPP coach is identified as having any of the above felony requirements, this would not constitute a denial under this category for the MDPP supplier, as the coach, not the supplier has the felony charge. The MDPP supplier would, however, have an enrollment denial under non-compliance for having an ineligible coach.

Contractors shall submit all felonies found on CMS-855 and CMS-20134 forms to PEOG for review via the ProviderEnrollmentRevocations@cms.hhs.gov.

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

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

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

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

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

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

i. Background

Consistent with 42 CFR §424.530(a)(6), an enrollment application may be denied if: (1) the current owner (as that term is defined in 42 CFR §424.502) of the applying provider or supplier, or (2) the applying physician or non-physician practitioner, has an existing overpayment that is equal to or exceeds a threshold of \$1,500 and it has not been repaid in full at the time the application was filed.

Specifically,

- (A) The enrolling provider, supplier, or owner (as defined in § 424.502) thereof has an existing Medicare debt.
- (B) The enrolling provider, supplier, or owner (as defined in §424.502) thereof was previously the owner of a provider or supplier that had a Medicare debt that existed when the latter's enrollment was voluntarily terminated, involuntarily terminated, or revoked, and all of the following criteria are met:
 - (1) The owner left the provider or supplier with the Medicare debt within 1 year before or after that provider or supplier's voluntary termination, involuntary termination or revocation.
 - (2) The Medicare debt has not been fully repaid.
 - (3) CMS determines that the uncollected debt poses an undue risk of fraud, waste, or abuse.

In making this determination under §424.530(a)(6)(ii), CMS considers the following factors:

- (a) The amount of the Medicare debt.
- (b) The length and timeframe that the enrolling provider, supplier, or owner thereof was an owner of the prior entity.
- (c) The percentage of the enrolling provider, supplier, or owner's ownership of the prior entity.
- (d) Whether the Medicare debt is currently being appealed.
- (e) Whether the enrolling provider, supplier, or owner thereof was an owner of the prior entity at the time the Medicare debt was incurred.

ii. A denial of Medicare enrollment under paragraph (a)(6) can be avoided if the enrolling provider, supplier or owner thereof does either of the following:

- (a) Satisfies the criteria set forth in § 401.607 and agrees to a CMS-approved extended repayment schedule for the entire outstanding Medicare debt; or
- (b) Repays the debt in full.

iii. Contractor's Determination of Overpayment

The contractor shall abide by the following:

- a. When processing a Form CMS-855A, CMS-855B, CMS-855S or CMS-20134 initial or change of ownership application, determine – using a system generated monthly listing – whether the applicant or any of the owners listed in section 5 or 6 of the application has an existing or delinquent Medicare overpayment.

b. When processing a Form CMS-855I initial application, determine – using a system generated monthly listing - whether the physician or any non-physician practitioner has an existing or delinquent Medicare overpayment.

If an owner, physician, or non-physician practitioner has such an overpayment, the contractor shall deny the application, using 42 CFR §424.530(a)(6) as the basis. However, prior approval from CMS' Provider Enrollment & Oversight Group (PEOG) is required before proceeding with the denial. The contractor shall under no circumstances deny an application under §424.530(a)(6) without receiving PEOG approval to do so.

c. Consider the following examples:

Example #1: Hospital X has a \$200,000 overpayment. It terminates its Medicare enrollment. Three months later, it reopens as Hospital Y and submits a new Form CMS-855A application for enrollment as such. A denial is not warranted because §424.530 (a)(6) only applies to physicians, practitioners, and owners.

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

Example #3 - Same scenario as example #2, but assume that his new practice is an LLC of which he is only a 30 percent owner. A denial is not warranted because the provision applies to owners and, again, the \$50,000 overpayment was attached to him.

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

d. Excluded from denial under §424.535(a)(6) are individuals or entities (1) on a Medicare-approved plan of repayment or (2) whose overpayments are currently being offset or being appealed.

e. The contractors shall also observe the following:

1. In determining whether an overpayment exists, the contractor need only review its own records; it need not contact other contractors to determine whether the person or entity has an overpayment in those contractor jurisdictions.

2. The instructions in this section 10.4(H)(3) apply only to (1) initial enrollments, and (2) new owners in a change of ownership.
3. The term “owner” under section §424.502 means any individual or entity that has any partnership interest in, or that has 5 percent or more direct or indirect ownership of the provider or supplier as defined in sections 1124 and 1124A(A) of the Act)
4. If the person or entity had an overpayment at the time the application was filed but repaid it in full by the time the contractor performed the review described in this section 10.4(H)(3), the contractor shall not deny the application based on 42 CFR §424.530(a)(6).

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

The provider, supplier or any owning and managing employee or organization of the provider or supplier has been placed under a Medicare or Medicaid payment suspension at the time the denial is issued, as defined in §405.370 through §405.372.

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

An HHA submitting an initial application for enrollment:

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

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

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

(This denial reason should only be used when the institutional provider fails to submit the application fee after its hardship request was denied. The contractor shall use 42 CFR §424.530(a)(1) as a basis for denial when the institutional provider:

- a. Does not submit a hardship exception request and fails to submit the application fee within the prescribed timeframes, or
- b. Submits the fee, but it cannot be deposited into a government-owned account.

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

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

K. Denial Reason 11– DEA Certificate/State Prescribing Authority Suspension or Revocation (42 CFR §424.530(a)(11))

1. A physician or eligible professional's Drug Enforcement Administration (DEA) Certificate of Registration to dispense a controlled substance is currently suspended or revoked; or
2. The applicable licensing or administrative body for any State in which a physician or eligible professional practices has suspended or revoked the physician or eligible professional's ability to prescribe drugs, and such suspension or revocation is in effect on the date the physician or eligible professional submits his or her enrollment application to the Medicare contractor.

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

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

- Owning and managing organizations and individuals (regardless if the organizations or individuals are disclosed on the CMS-855 or CMS-20134 application);
- Geographic location;
- Provider or supplier type;
- Business structure; or
- Any evidence that the two parties (the revoked provider or supplier and newly-enrolling provider or supplier) are similar or that the provider or supplier was created to circumvent the revocation or re-enrollment bar.

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

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

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

An affiliation is defined as:

- A 5 percent or greater direct or indirect ownership interest that an individual or entity has in another organization.
- A general or limited partnership interest (regardless of the percentage) that an individual or entity has in another organization.

- An interest in which an individual or entity exercises operational or managerial control over, or directly or indirectly conducts, the day-to-day operations of another organization (including, for purposes of § 424.519 only, sole proprietorships), either under contract or through some other arrangement, regardless of whether or not the managing individual or entity is a W–2 employee of the organization.
- An interest in which an individual is acting as an officer or director of a corporation.
- Any reassignment relationship under § 424.80.

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

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

- The provider or supplier is currently terminated or suspended (or otherwise barred) from participation in a state Medicaid program or any other federal health care program; or
- The provider or supplier’s license is currently revoked or suspended in a state other than that in which the provider or supplier is enrolling. In determining whether a denial is appropriate, CMS considers the following factors:
 - The reason(s) for the termination, suspension, or revocation,
 - Whether, as applicable, the provider or supplier is currently terminated or suspended (or otherwise barred) from more than one program (for example, more than one State’s Medicaid program), has been subject to any other sanctions during its participation in other programs or by any other State licensing boards or has had any other final adverse actions (as that term is defined in § 424.502) imposed against it, and
 - Any other information that CMS deems relevant to its determination.

NOTE: With respect to (a)(14), PEOG -- rather than the contractor – will make all determinations regarding whether a provider or supplier has an termination or suspension from another program.

vi. 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 initial denial was not appealed, the provider or supplier’s appeal rights have lapsed, or
- If the initial denial was appealed, the provider or supplier has received notification that the determination was upheld, or

- The reapplication bar has expired, if applicable.

Contractors shall return an application that is submitted before these have occurred.

vii. 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, with PEOG approval, 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.

b. Other Impacts of a Denial

i. 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 10.4(H)(3) and the applicable 90-day or 30-day period for reporting the change has expired, the contractor shall send an e-mail to the CMS MedicareProviderEnrollment@cms.hhs.gov mailbox notifying PEOG 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 10.4(H)(3)(b)(i)(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 10.4(H)(3)(b)(i)(B), the provider resubmits the change of information or CHOW application and the contractor either denies it again, returns it per section 10.4(H)(1) of this chapter, or rejects it per section 10.4.8.2 of this chapter, the contractor shall send the e-mail referred to in 10.4(H)(3)(b)(i)(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.

ii. Reactivations

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

iii. Revalidations

If the contractor denies a revalidation application per this section 10.4(H)(3), the contractor shall – unless an existing CMS instruction or directive dictates otherwise - deactivate the provider's Medicare billing privileges 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 10.4(H)(1) of this chapter, or (3) rejects it per section 10.4(H)(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.

4. Provider Enrollment Appeals Process – Denials

For more information regarding the provider enrollment appeals process, see Pub. 100-08, Chapter 15, Section 15.25.

I. Terminations – Voluntary and Involuntary

1. Voluntary Terminations of Certified Providers and Suppliers

Regulations in 42 CFR §489.52, a provider of services may terminate its agreement with CMS. Voluntary terminations shall be processed in accordance with the timeframes in section 10.4(I), et al. of this chapter.

a. If the termination involving a certified provider or supplier is received via a CMS-855 application (paper or electronic application), the contractor shall deactivate the entity per their request as a voluntary termination in the Provider Enrollment Chain and Ownership System (PECOS) and notify the provider or supplier. Within 3 business days of processing the termination, the contractor shall notify the State Agency (SA) and Regional Office (RO) of the action via e-mail. The termination date of certified providers and suppliers must not be more than 6 months from the date the notice is filed, according to 42 CFR §489.52(b)(2). Contractors shall consult the appropriate RO should a certified providers and supplier submit a termination date more than 6 months from the date the notice is filed.

If the contractor is setting a termination effective date that is less than 6 months in the future, contractors shall consider the availability of other facilities in the area and not unduly disrupt the services to the community or otherwise interfere with the effective and efficient administration of the health insurance program. Contractors shall consult the appropriate RO for assistance when these situations arise.

b. Within 3 business days of processing the termination, the contractor shall notify the RO and SA of the termination via e-mail.

c. If the SA does not renew a certified provider or supplier's license to operate, the SA will inform the contractor of the termination of the license. Contractors shall take revocation actions for non-compliance as directed in Section 10.4(M) of this chapter.

If the certified provider or supplier decides not to renew their state license to operate, the SA will inform the contractor of the termination of the license. The contractor shall notify the provider in writing, stating that the provider should submit an application to voluntary

terminate their enrollment and billing privileges. The letter must state that the provider must take action, but if no action is taken, the provider's enrollment and billing privileges will be deactivated. The enrollment shall be deactivated as a voluntary termination in PECOS and the contractor shall notify the certified provider or supplier. The contractor shall also notify the RO and SA via e-mail within 3 business days after processing the termination action.

d. A tie-out will not be issued to the contractors in the previous situations. If the provider is notified by the RO or SA, the contractor will be copied or if the contractor receives a voluntary termination, the contractor will process the deactivation and notify the RO and/or SA. There is no need for additional communication following these activities.

e. According to 42 CFR §489.52(b)(3), the effective date of voluntary termination is the date business ceased providing services to the community. If a retroactive termination date is requested, this is permissible, provided there were no Medicare beneficiaries receiving services from the facility on or after the requested termination date (contractors shall confirm this via a claims review prior to approving the retroactive termination). If claims were submitted, contractors shall reach out to the provider to confirm that services were indeed rendered and adjust the term date with the provider, if no adjustment is made or contact cannot be made, an overpayment request must be issued.

f. Upon receipt of a voluntary termination for a certified providers or suppliers, the contractor may ask the provider or supplier to complete the "Special Payments" portion of section 4 of the Form CMS-855 or CMS-20134 so that future payments can be sent thereto. The addition should be included in the same transaction as the termination (i.e., one transaction incorporating both items). If the provider or supplier wants to change its existing special payments address, the transaction should be treated as a separate change request (i.e., one termination and one change request). The provider or supplier is not required to submit a Form CMS-588 in conjunction with a termination.

2. Voluntary Terminations of Non-certified Suppliers

Voluntary terminations shall be processed in accordance with the timeframes Pub. 100-08, Chapter 15, Section 15.6, et al.

a. When processing a voluntary termination of a non-certified supplier, the contractor shall only accept the request via application (form CMS-855 or the equivalent electronic application via Internet-Based PECOS). Non-certified suppliers cannot submit a termination request via letter.

b. When processing a voluntary termination of a reassignment, the contractor shall contact the group to confirm that: (1) the group member PTAN is being terminated from all locations; and (2) if multiple group member PTANs exist for multiple group locations, each PTAN is terminated. However, if a group has one PTAN with multiple addresses, the contractor need not contact the group to confirm the termination.

c. When processing a voluntary termination of a reassignment, the contractor shall terminate non-certified suppliers effective the day after the supplier requests in its termination application.

d. Upon receipt of a voluntary termination of certified or non-certified providers or suppliers, the contractor may ask the provider or supplier to complete the "Special Payments" portion of section 4 of the Form CMS-855 or Form CMS-20134 so that future

payments can be sent thereto. If the provider or supplier has no special payments address already on file, the addition should be included in the same transaction as the termination (i.e., one transaction incorporating both items). If the provider wants to change its existing special payments address, the transaction should be treated as a separate change request (i.e., one termination and one change request). The provider is not required to submit a Form CMS-588 in conjunction with a termination.

3. Involuntary Terminations

a. Tie-Out Notice

If the contractor receives a tie-out notice from the RO that involuntarily terminates the provider or supplier's Medicare participation because the provider or supplier no longer meets the conditions of participation, the contractor need not send a letter to the provider or supplier notifying it that its Medicare participation has been terminated. The RO will issue such a letter and afford appeal rights. The contractor shall adhere to the instructions in section 10.4(M)(2)(b)(i) of this chapter with respect to revoking the provider or supplier's enrollment, as the provider or supplier is no longer in compliance with Medicare enrollment regulations. **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 with.

The revocation shall be recorded in PECOS using the status reason of "Non-Compliance: Provider/Supplier Type Requirements Not Met." Contractors shall not identify the involuntary termination action in PECOS as a Deactivation with a status reason of "Voluntarily Withdrawal from the Medicare Program."

b. Revocation Letter

In addition, contractor shall issue a revocation letter to the certified provider or supplier using 42 CFR §424.535(a)(1), as the legal basis for the revocation. The letter shall also contain the effective date of the revocation, appeal rights and the length of the enrollment bar as determined by CMS and indicated to the contractor. The issuance of the Tie-Out for non-compliance of CMS enrollment requirements, conditions of participation, or conditions of coverage is sufficient to revoke.

c. State Agency Site Survey Results

If the SA performs a site survey as a result of a complaint or cessation of business and finds the certified provider or supplier has vacated the practice location and is no longer operational, the SA will notify the contractor. The contractor shall send a notice, located in Section 10.7.2 of this chapter, to the certified provider or supplier requesting that they: (1) provide evidence to the contractor and SA showing they are still operational, (2) submit a request to the contractor to voluntarily terminate their enrollment or (3) submit a request to the contractor to update their enrollment information (e.g. change in practice location). The SA and RO shall be copied on the notice. Certified providers and suppliers shall be given 10 days to respond to the request.

If the certified provider or supplier is operational, they must provide evidence to support their position to the contractor with a copy to the SA. The SA will conduct a review and a new survey within 15 days of receiving the certified provider or supplier's evidence. The SA will forward the outcome to the contractor with a copy to the RO. The contractor shall not take any action until they receive notification from the SA. If only the contractor

receives a response from the provider or supplier, the contractor shall notify the RO. The RO will notify the SA that a second site survey should be performed, if the provider has indicated that it is open and operational or issue a voluntary termination if the provider or supplier has indicated they are no longer operational.

If the certified provider or supplier submits a CMS-855 application to terminate their enrollment to the contractor, they shall process the termination in PECOS and notify the certified provider or supplier. The contractor shall notify the RO and SA via e-mail within 3 business days after processing the termination action.

If the certified provider or supplier submits a CMS-855 application to change their enrollment information, the contractor shall process the change and inform the SA, via e-mail, that a survey of the new practice location is required once the change is processed, in accordance with Section 10.3.1(A) of this chapter.

If the certified provider or supplier does not respond to the contractor's request, the contractor shall deactivate the enrollment as a voluntary termination in PECOS and notify the certified provider or supplier. The contractor shall notify the RO and SA, via e-mail, within 3 business days after processing the termination action.

4. Additional Information

For more information on voluntary terminations, refer to:

- Section 1866(b)(1) of the Social Security Act
- 42 CFR 489.52(b)
- Pub. 100-07, chapter 3, section 3046 (SOM)

J. Changes of Information

Unless indicated otherwise, the instructions in sections 10.4(J) through 10.4(J)(7) of this chapter apply to Part A and Part B enrollments.

Unless otherwise specified in this chapter or another CMS directive, if an enrolled provider is adding, deleting, or changing information under its existing tax identification number, it must report the change using the applicable Form CMS-855 or CMS-20134. Letterhead is not permitted.

The provider shall (1) furnish the changed data in the applicable section(s) of the form, and (2) sign and date the certification statement. In accordance with 42 CFR §424.516(d) and (e), the timeframes for providers to report changes to their Form CMS-855 or CMS-20134 information are as follows:

1. Changes of Information: Complete Form CMS-855 or CMS-20134 Applications

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

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

If the provider fails to submit a complete application within the aforementioned 30-day period, the contractor shall follow the instructions in section 10.4(H)(2) of this chapter.

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

- Processing the complete application consistent with the timeframes for initial applications in Pub. 100-08, Chapter 15, Section 15.6, et al.
- Ensuring that all data elements on the Form CMS-855 or CMS-20134 have been validated, as it would with an initial enrollment application. The contractor shall not approve the change request until all data on the complete Form CMS-855 or CMS-20134 has been validated.
- Creating an L & T record and enrollment record in PECOS prior to approving the change request. (The receipt date should be the date on which the complete application was received, not the date on which the initial change request was received.) The transaction should be treated as an initial enrollment in PECOS; internally, the contractor shall treat it as a change of information. As the complete application will presumably incorporate the changed data reported on the original Form CMS-855 or CMS-20134 change request, the contractor shall not take two separate counts (one initial and one change request) for the transaction.

2. Requirements for a Provider or Supplier to Report Changes of Information Via a Form CMS-855 or Form CMS-20134 Application

a. Information a Provider or Supplier Must Report Within 30 Days

Pursuant to 42 CFR 424.516(d), changes of information requirements apply to physicians and non-physician practitioners and physician and non-physician practitioner organizations (i.e.: clinic/group practices).

For these provider types, the following changes must be reported within 30 days:

- A change of ownership
- Adverse legal action
- A change in practice location

Suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS);
and
Independent diagnostic testing facilities (IDTFs):

For these providers/suppliers, the following changes must be reported within 30 days:

Any change of ownership or control, including a change in an authorized or delegated official.

All other informational changes involving the providers listed in this section 10.4(J)(2)(a) must be reported within 90 days.

b. Information a Provider or Supplier Must Report Within 90 Days

Pursuant to 42 CFR 424.516(e), change of information requirements apply to the following providers and suppliers:

All providers and suppliers other than those listed in section 10.4(J)(2)(a) above.

3. Additional Guidance Concerning Specific Changes of Information

- **Application Signatures** - If the signer has never been reported in section 6 of the Form CMS-855 or CMS-20134, section 6 must be completed in full with information about the individual. (This policy applies regardless of whether the provider already has a Form CMS-855 or CMS-20134 on file.) The contractor shall ensure that all validation required to be performed with respect to the individual is conducted.
- **Notifications** – For changes of information that do not require Regional Office approval (e.g., Form CMS-855I changes; Form CMS-855B changes not involving ambulatory surgical centers or portable x-ray suppliers; minor Form CMS-855A changes), the contractor shall (1) furnish written, e-mail, or fax confirmation to the provider that the change has been made, and (2) document (per Pub. 100-08, Chapter 15, Section 15.24) in the file the date and time the confirmation was made. If, however, the transaction only involves an area code/ZIP Code change, it is not necessary to send confirmation to the provider that the change has been processed.

a. Change in Practice Location Address

In cases where a provider submits a Form CMS-855 or Form CMS-20134 request to change its practice location address, the contractor shall contact the location currently associated with the provider in 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.

b. Change in Special Payments Address

If the provider submits a change to its special payments address, the contractor shall contact the individual physician/practitioner (for Form CMS-855I changes), an authorized or delegated official (for Form CMS-855A, Form CMS-855B, and Form CMS-20134 changes), or the contact person listed in section 13 (for Form CMS-855A, Form CMS-855B, Form CMS-20134, and Form CMS-855I changes) 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.

When processing a revalidation or Form CMS-855 or Form CMS-20134 reactivation application, the contractor shall – unless another CMS directive instructs otherwise - abide by the instructions in subsections 10.4(J)(3)(a) and 10.4(J)(3)(b) above, respectively, if the (a) practice location address or (b) special payment address on the application is different than that which is currently associated with the provider in PECOS or MCS.

c. Provider or Supplier Changing Specialty Type

With the exception of individual physicians, providers or suppliers (including non-physician practitioners) who wish to change their enrolled provider or supplier type must deactivate their current enrollment and submit an initial enrollment application (screening and an application fee applies as applicable).

4. Incomplete or Unverifiable Changes of Information

The contractor shall follow the instructions in this section 10.4(J)(4) if a submitted change request cannot be processed to completion.

In regards to unresponsive Providers or Unverifiable Changes, if a provider has an established enrollment record in the Provider Enrollment, Chain and Ownership System (PECOS) assume that a provider with a PECOS enrollment record submits a Form CMS-855 or CMS-20134 change request and (1) fails to timely respond to the contractor's request for additional or clarifying information, or (2) the changed information cannot be validated. The contractor shall reject the change request in accordance with section 10.4(H)(2) of this chapter. Moreover, if the changed information is of such materiality that the contractor cannot determine whether the provider still meets all enrollment requirements, the contractor shall refer the matter to its Provider Enrollment Oversight Group (PEOG) Business Function Lead (BFL) for guidance. Examples include but are not limited to:

- change in the provider's lone practice location,
- change in ownership, or
- change in EFT information.

5. 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 contact the individual physician/practitioner (for Form CMS-855I enrollees), an authorized or delegated official on record (for Form CMS-855A, CMS-855B and Form CMS-20134 enrollees), or the section 13 contact person on record (for Form CMS-855A, Form CMS-855B, Form CMS-20134 and Form CMS-855I enrollees) to verify the change. 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.

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

a. Timeframe for Regional Office (RO) Approval

In situations where RO approval of the change of information is required, it is strongly recommended that the contractor advise the provider that it may take up to 6 months (or

longer) for the request to be approved. The manner and timing in which this information is relayed lies solely within the contractor's discretion.

b. Post-Recommendation Changes

If an applicant submits a change request after the contractor makes a recommendation on the provider's initial CMS-855 application but before the RO issues a tie-in/approval notice, the contractor shall process the newly-submitted data as a separate change of information; it shall not take the changed information/corrected pages and, immediately upon receipt, send them directly to the State/RO to be incorporated into the existing application. The contractor, however, need not enter the change request into the Provider Enrollment, Chain and Ownership System (PECOS) until the tie-in notice is issued.

In entering the change request into PECOS, the contractor shall use the date it received the change request in its mailroom as the actual receipt date in PECOS; the date the tie-in notice was issued shall not be used. The contractor shall explain the situation in the "Comments" section in PECOS and in the provider file.

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

i. Verifying Distance Requirements with the CMS Regional Offices

Regulations found at 42 CFR 485.610(e)(2) and in the State Operations Manual (SOM), Pub. 100-07, Chapter 2, Section 2256H state that the CAH's provider-based location must meet certain distance requirements from the main campus of another hospital or CAH.

The MAC shall reach out to the appropriate CMS Regional Office (RO) Division of Survey and Certification (DSC) during the processing of the CMS-855A for a verification that the CAH's new provider-based location is more than 35 miles (15 miles in the case of mountainous terrain or an area with only secondary roads) from the main campus of another hospital or CAH. The MAC's recommendation of approval cannot be made without receiving a response from the RO DSC.

If the RO DSC finds that CAH's new provider-based location meets the distance requirements, the RO DSC will send a response to the MAC stating this. When this communication is received, the MAC shall continue processing as usual, up through issuing a recommendation of approval to the appropriate RO and/or State Agency (SA). If the RO DSC responds that the new provider-based location does not meet the distance regulations, the MAC shall issue the rejection letter found below to CAH. The application shall be rejected in PECOS.

The CAH will be provided three options by the RO DSC if it does not meet the distance requirements:

1. The CAH keeps the new provider-based location, which will cause an involuntary termination in 90 days (as outlined in the State Operations Manual, Pub. 100-07, Chapter 3, Section 3012).
2. The CAH will terminate the new provider-based location and continue their enrollment as a CAH.
3. The CAH keeps the new provider-based location, but converts to a hospital (as outlined in the State Operations Manual, Pub. 100-07, Chapter 2, Sections 2256G and

2256H).

For each of these options, the MAC will keep the CAH's enrollment in an approved status in PECOS. In the case of option (a) above, the MAC will receive a tie-out notice for termination, which will lead to revocation of the CAH's enrollment. For option (b), the CAH's enrollment remains approved and the MAC shall expect no further communication from the RO DSC. If the CAH chooses option (c) to convert to a hospital, the MAC will receive a CMS-855A to terminate the CAH's enrollment and a new CMS-855A to enroll as a hospital.

ii. Rejection Letter for Locations That Do Not Meet the Distance Requirements

[month] [day], [year]

[Provider/Supplier Name]

[Address]

[City] ST [Zip]

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

Dear [Provider/Supplier Name]:

We received your Medicare enrollment application(s) to add a new provider-based location to your Critical Access Hospital enrollment on [date]. We are rejecting your application because the CMS Regional Office, Division of Survey and Certification (RO DSC) has found that your new location does not meet distance requirements found in 42 CFR 485.610(e)(2).

Please refer to communications from the RO DSC for instructions for your next steps regarding the new provider-based location.

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

Sincerely,

[Name]

[Title]

[Company]

7. Additional Reporting Requirements for IDTFs and DMEPOS Suppliers

Additional reporting requirements for IDTFs can be found in 42 CFR §410.33(g)(2) and in section 10.2(I)(2) of this chapter. Reporting requirements for DMEPOS suppliers can be found in 42 CFR §424.57(c)(2).

K. Revalidation of Providers and Suppliers

The contractor shall follow the guidance provided in sections 10.4(K) through 10.4(K)(15) when processing revalidation applications, unless indicated otherwise in another CMS directive. Also, this guidance takes precedence over all other instructions in this chapter 15 with respect to revalidation processing unless, again, another CMS directive specifies otherwise.

Consistent with section 6401(a) of the Patient Protection and the Affordable Care Act (ACA), all existing providers and suppliers are required to revalidate their enrollment information under new enrollment screening criteria. Providers and suppliers are normally required to revalidate their Medicare enrollment every 5 years (every 3 years for suppliers of Durable Medical Equipment, Prosthetics Orthotics and Supplies (DMEPOS)). However, CMS reserves the right to perform off-cycle revalidations as deemed necessary.

1. Revalidation Lists

The CMS will identify the providers and suppliers required to revalidate during each cycle. CMS will communicate when new lists become available through the appropriate channels, at which time the contractor shall obtain the list from the CGI Share Point Ensemble website.

The list will contain a suggested revalidation due date, consisting of a month and day of the year, to assist contractors in staggering their workload and distributing the e-mails or mailings evenly. Contractors shall review the list and may alter a provider/suppliers' due date month based on staffing levels and workload. However, the day that the revalidation is due shall always remain as the last day of each month (i.e., June 30th, July 31st, or August 31st). When distributing the workload, contractors shall ensure that the revalidation due dates are divided equally over a 7 month period and accounts for fifty percent of the contractor's list (i.e., 50 percent of the revalidation due dates are defined in the first 7 months, and the remaining 50 percent in the last 7 months). Contractors shall also ensure that the due dates selected do not go beyond the current year.

Once the contractor confirmed lists are received by CMS, a final list will be generated capturing the provider/supplier's due date and timeframes for each revalidation action (i.e., e-mail or mail date, pend, deactivation). The list will be posted to the CGI Share Point Ensemble site and will be refreshed with updated enrollment data every 60 days to account for providers/suppliers who have been deactivated or have had changes in the provider/supplier's enrollment information. Contractors shall use the most current list available to conduct their e-mails or mailings and shall allow sufficient time for the provider/supplier to meet their deadline (between 90 to 105 days prior to the revalidation due date).

This list will also be made available on <https://data.cms.gov/revalidation> so that providers and suppliers are aware of who has been selected to revalidate.

2. Mailing Revalidation Letters

Based on the due date identified on the list, contractors shall send a revalidation notice between 90 to 105 days prior to the revalidation due date using the sample letter provided in Pub. 100-08, Chapter 15, Section 15.24.5, et al. The initial revalidation letter may include a generic provider enrollment signature; however, development letters shall include a provider enrollment analyst's name and phone number for provider/supplier contacts. Contractors may send revalidation notices via email if this option is in line with the Contractor's security

requirements and capabilities. Email addresses will be provided as part of the CMS list (derived from Section 2 and 13 of PECOS). When sending revalidation notices via email, contractors shall indicate “URGENT: Medicare Provider Enrollment Revalidation Request” in the subject line to differentiate this from other emails. The sample letter provided in Pub. 100-08, Chapter 15, Section 15.24.5, et al. should be included in the body of the email and should not be included as an attachment to the email or require a password be sent to the provider/supplier to view the email content. Contractors are not required to send a paper copy of the revalidation notice if sent via email. If the notice is sent to multiple email addresses but one is returned as undeliverable, contractors are not required to mail a revalidation notice as long as one email is delivered successfully.

If all of the emails are returned as undeliverable, paper revalidation notices shall be mailed to the provider/supplier’s correspondence and special payment addresses, within the 90 to 105 day timeframe prior to the revalidation due date. If the correspondence and special payment address is the same, contractors shall send the second letter to the provider/supplier’s practice location address. If the correspondence, practice and special payments address are the same, only one letter shall be sent.

If no email addresses exist in the enrollment record or the contractor chooses the mail option, contractors shall mail two revalidation notices to the provider/supplier’s correspondence and special payment address and/or practice location address using the instructions outlined above.

When issuing revalidation notices to individual group members, contractors shall provide on the revalidation notice identifying information of the organization (s) (i.e., Legal Business Name (LBN), Doing Business As (DBA) name, Tax Identification Number) that the provider reassigns benefits in lieu of including the provider’s PTANs. Individual group members may be more familiar with the LBN or DBA name of the organizations they are associated versus the PTANs. This should eliminate contractors developing for PTANs not included on the revalidation application.

If one of the locations is found to be incorrect or the letter gets returned as undeliverable, the contractor shall re-send the returned letter to an address not used for the initial mailing. If it is determined that all locations are the same and the contractor has exhausted all reasonable means of contacting the provider/supplier, the contractor shall deactivate the provider/supplier’s enrollment in either MCS/FISS or PECOS, whenever possible.

3. Non-Response to Revalidation Actions

a. Phone Calls

Contractors may continue to contact providers/suppliers via telephone or email to communicate non-receipt of revalidation applications; however, these contacts are not required.

If telephone or email contacts are made, contractors shall continue to document all communications with the providers/suppliers.

b. Pend Status

Contractors shall apply the payment hold (pend flag) in PECOS if the provider/supplier fails to respond to the revalidation request. MACs shall perform this action within 25 days

after the revalidation due date. Contractors may, but are not required to notify the provider/supplier of the payment hold.

Since there is no way to assign a payment hold to an individual group member without it preventing payment to the entire group, contractors shall issue a letter to the individual group members in lieu of the payment hold within 25 days after the revalidation due date using the sample letter provided in Pub. 100-08, Chapter 15, Section 15.24.5.5 (Revalidation Past Due Group Member Sample Letter). Contractors may send the payment hold notice via email if this option is in line with the contractor's security requirements and capabilities. Email addresses will be provided as part of the CMS list (derived from Section 2 and 13 of the Provider Enrollment Chain and Ownership System (PECOS)). When sending payment hold notices via email, contractors shall indicate "URGENT: Revalidation Past Due" in the subject line to differentiate this from other emails. The letter should be included in the body of the email and should not be included as an attachment to the email or require a password be sent to the provider/supplier to view the email content. Contractors are not required to send a paper copy of the payment hold notice if sent via email. If the notice is sent to multiple email addresses but one is returned as undeliverable, contractors are not required to mail a payment hold notice as long as one email is delivered successfully.

If all of the emails are returned as undeliverable, paper payment hold notices shall be mailed to the provider/supplier's correspondence and special payment addresses. If the correspondence and special payment address is the same, contractors shall send the second letter to the provider/supplier's practice location address. If the correspondence, practice and special payments address are the same, only one letter shall be sent.

If no email addresses exist in the enrollment record or the contractor chooses the mail option, contractors shall mail the two payment hold notices to the provider/supplier's correspondence and special payment address and/or the practice location address using the instructions outlined above.

This requirement shall only apply to individual group members who are reassigned to a group and/or providers who have employment arrangements.

c. Deactivation Actions

Contractors shall deactivate a provider/supplier's enrollment record for failure to respond to the revalidation request between days 60 – 75 after the revalidation due date and notify the provider/supplier using the sample letter provided in Pub. 100-08, Chapter 15, Section 15.24.5.4. (Model Revalidation Deactivation Letter).

The contractor shall establish the effective date of deactivation as the same date the action is being taken.

If an individual provider is deactivated for failure to respond to a revalidation request, the contractor shall search the provider's associate record to determine if the provider is identified as a supervising physician on any independent diagnostic testing facility (IDTF) enrollments. If so, the provider shall be disassociated as the supervising physician for that entity. If the deactivated provider is the only supervising physician on file for the IDTF, the contractor shall develop for an active supervising physician to bring the IDTF into compliance. The contractor shall give the IDTF 30 days to respond. Failure to provide an active supervising physician in the designated timeframe shall result in revocation of the IDTF's billing privileges for non-compliance with the IDTF standards.

4. Receipt of Revalidation Application

Contractors shall return all unsolicited applications. Unsolicited applications are: (1) revalidation applications received more than 7 months prior to the provider/suppliers established due date and/or (2) Providers and suppliers identified as TBD (To Be Determined) on the revalidation look up tool. Contractors shall return these applications using the sample return letter template provided in Pub. 100-08, Chapter 15, Section 15.24.5.7, within 20 business days of receipt. Contractors shall also submit a request to CMS to have the application fee returned to the provider.

Revalidation applications submitted within 7 months of their due date shall be accepted and processed by the contractor. The submission date of a revalidation application for providers/suppliers who are on the CMS posted list will not alter their future revalidation due date. The contractor may only accept revalidation applications signed by the individual provider or the authorized official (AO) or delegated official (DO) of the provider/supplier organization.

If a provider/supplier wishes to voluntary withdrawal from Medicare (including deactivating all active PTANs), the contractor shall accept this request via phone, U.S. mail or fax from the individual provider or the AO/DO (on letterhead); the contractor shall not require the provider/supplier to complete a CMS-855 or CMS-20134 application. If the request is made via telephone, the contractor shall document the telephone conversation (in accordance with section 10.6.19(I) of this chapter) and take the appropriate action in PECOS.

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

If the provider/supplier requests to collapse its PTANs as a result of revalidation, the contractor shall process those requests, if appropriate (based on payment localities, etc.).

5. Revalidation Application Received and Development Required

If the revalidation application is received but requires development (i.e., missing application fee, hardship request, reassignments and/or employment arrangements, documentation, signature, etc.), the contractor shall notify the provider or supplier via mail, phone, fax or email. Contractors shall develop for all of the missing information in one development request. Providers and suppliers shall be given 30 days to respond to the contractor's request and may submit the missing information via mail, fax, or e-mail containing scanned documentation (this includes missing signatures and dates). The provider may submit a full 855I or sections 1, 2, 4, & 15 of the 855I to report the missing reassignments and/or employment arrangements any time prior to their revalidation due date, even post revalidation application approval.

If licensure and/or educational requirements (i.e., non-physician practitioner's degree or diploma) can be verified online, the contractor shall not require the provider/supplier to submit this documentation. If the supporting documentation currently exists in the provider's file, the provider or supplier is not required to submit that documentation again with their

revalidation application. The contractor may utilize the existing documentation for verification. Residency information shall also not be required as part of revalidation. The contractor shall not require further development for data that is missing on the provider/supplier's revalidation application if the information is disclosed (1) elsewhere on the application, or (2) in the supporting documentation submitted with the application with the exception of the following items:

- Adverse legal action data
- Legal business name (LBN)
- Tax identification number (TIN)
- NPI-legacy number combinations
- Supplier/Practitioner type
- "Doing business as" name
- Effective dates of sale/transfer/consolidation or indication of acceptance of assets/liabilities

Contractors shall not require providers/suppliers to include the PTAN(s) in section 2 or 4 on the revalidation application, provided they have included the necessary information (NPI, TIN, LBN, DBA, etc.) for the contractors to appropriately make the association. If the PTAN is not submitted but is needed to make the connection, contractors shall use the shared systems, PECOS or their provider files as a resource before developing back to the provider/supplier.

Contractors shall not develop for the EFT form if the provider/supplier has either the 05/2010 or 09/13 version of CMS 588 (EFT) on file. If an EFT form is submitted along with a bank letter or voided check, contractors may verify that the LBN matches and develop to process the application accordingly.

If the supporting documentation currently exists in the provider's file, the provider or supplier is not required to submit that documentation again during the enrollment process. The contractor shall utilize the existing documentation for verification. Documentation submitted with a previously submitted enrollment application, or documentation currently uploaded in PECOS, qualifies as a processing alternative, unless stated otherwise in this chapter or any CMS directive. In addition, per section 15.7.3 of this chapter, the contractor shall document in the provider file that the missing information was found elsewhere in the enrollment package, with previously submitted applications or documentation currently uploaded in PECOS. This excludes information that must be verified at the current point in time (i.e. a license without a primary source verification method). Additionally, contractors shall not utilize information submitted along with opt-out applications for enrollment application processing or vice-versa.

In scenarios where a revalidation response is received for a single reassignment within an enrollment record that has multiple reassignments and/or employment arrangements, the contractor shall develop to the contact person (or the individual provider if a contact is not listed), for the remaining reassignments and/or employment arrangements not accounted for. If no response is received within 30 days, the contractor shall revalidate the single

reassignment and deactivate the reassignments and/or employment arrangements within the enrollment records that were not revalidated.

The deactivation date shall be consistent with the latter of: (1) the revalidation due date, or (2) the date deactivation action is taken due to non-response or incomplete response to a development request for all provider and supplier business structures (i.e. organizations, sole proprietors, sole owners, etc.).

To illustrate, in scenario #1 the contractor issues a revalidation notice to the provider and includes reassignments and/or employment arrangements for Groups A, B & C. The provider submits the revalidation application to the contractor but only addresses the reassignment for Group A. The contractor develops to the contact person for the missing reassignments and/or employment arrangements for Groups B & C. The provider responds with the reassignment information for Groups B & C prior to the development due date. Since the revalidation application is still considered in progress, the provider may submit a full 855I or sections 1, 2, 4, & 15 of the 855I to report the missing reassignment information, even post revalidation application approval. The revalidation application is processed to completion and the provider experiences no break in billing.

In scenario #2 the contractor issues a revalidation notice to the provider and includes reassignments and/or employment arrangements for Groups A, B & C. The provider submits the revalidation application to the contractor but only addresses the reassignment for Group A. The contractor develops to the contact person for the missing reassignments and/or employment arrangements for Groups B & C. No response is received within 30 days and the revalidation due date has passed.

Group A's reassignment is revalidated. Group B & C's reassignments and/or employment arrangements are deactivated effective with the date deactivation action is taken due to non-response or incomplete response to a development request. The approval letter issued by the contractor will identify the reassignments and/or employment arrangements that were revalidated and those terminated with the effective date of the reassignment or termination. The provider is required to submit a full application (CMS-855R) to reactivate the reassignment. The effective date for the reactivation is based on the receipt date of the CMS-855R. In this scenario the provider does experience a break in billing.

In this scenario, the entire enrollment shall not be deactivated; only the non-response reassignments and/or employment arrangements shall be deactivated and the other reassignments and/or employment arrangements revalidated.)

If other missing information is not received within 30 days, contractors shall deactivate the provider/supplier within 25 days after the development due date and notify the provider/supplier of the deactivation using the sample letter provided in Pub. 100-08, Chapter 15, Section 15.24.5.4. After deactivation, the provider shall be required to submit an entirely new application in order to reactivate their PTANs. Supporting documentation received may be used, if needed, for subsequent application submissions.

6. Revalidation Received after a Pend is Applied

The contractor shall remove the pend within 15 business days of receiving the revalidation application, even though the submitted application has not been processed to completion. This will release all held paper checks, SPRs, and EFT payments.

The contractor shall process the revalidation application using current processing instructions and mail, fax, or email a decision letter to the provider or supplier to notify it that the revalidation application has been processed.

7. Revalidation Received After a Deactivation Occurs

Contractors shall require the provider/supplier to submit a new full application to reactivate their enrollment record after they have been deactivated. The contractor shall process the application as a reactivation. The provider/supplier shall maintain their original PTAN but the contractor shall reflect a gap in coverage (between the deactivation and reactivation of billing privileges) on the existing PTAN using Action Reason (A/R) codes in the Multi-Carrier Claims System (MCS) based on the receipt date of the application. The provider will not be reimbursed for dates of service in which they were not in compliance with Medicare requirements (deactivated for non-response to revalidation). Group members whose reassignment association was terminated when the group was deactivated shall be reactivated with the group enrollment. The effective dates assigned to the reassigned providers should align with the group's effective date per standard reactivation instructions.

Since the issuance of PTANs and effective dates for Part A certified providers/suppliers, including ASC's and Portable X-Ray, are determined by the RO and the deactivation action does not terminate their provider agreement, contractors shall allow the provider/supplier to maintain its original PTAN and effective date when the reactivation application is processed.

When processing the revalidation application after a deactivation occurs, the contractor shall not require any provider/supplier whose PTAN(s) have been deactivated to obtain a new State surveyor accreditation as a condition of revalidation

8. Change of Information Received Prior to or After the Revalidation Letter is Mailed

If a change of information (COI) application is received from the provider/supplier prior to the contractor having mailed the revalidation letter, the contractor shall process the COI as normal and proceed with mailing the revalidation notice.

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

If a change of information (COI) application is received after the contractor has mailed the revalidation notice, the contractor shall (1) develop for a complete application containing the missing data elements, and (2) treat it as a revalidation.

9. Reassignments and/or Employment Arrangement Applications Received After Revalidation Letter Mailed

If the revalidation due date has been posted (7 months prior to revalidation due date) and a reassignment and/or employment arrangement application has been received within that 7 month timeframe, contractors shall process the reassignment and/or employment arrangement application. The newly established reassignment/employment arrangement is not required to be reported on the revalidation application and contractors shall not develop for the missing information, since they were established after the revalidation notice was issued. Contractors shall however, maintain the reassignment/employment arrangement information in the enrollment record when processing the revalidation application and this information shall not

be overridden. In the instance where the provider or supplier fails to respond to the revalidation request, all reassignments/employment arrangements shall be end dated, including the newly established reassignment/employment arrangement.

To illustrate, Dr. Doe submits a CMS-855R application to his contractor to add a new reassignment to Browns Medical Center. Soon after he checks <https://data.cms.gov/revalidation> and notices that he is due for revalidation in the next 7 months. He submits his revalidation application to his contractor but does not include the reassignment for Browns Medical Center since it is in progress and an approval notification has not been issued. The contractor finalizes the reassignment changes and then proceeds with processing the revalidation application. The contractor shall not develop for the new reassignment to Browns Medical Center and shall maintain the reassignment in the provider's enrollment record when processing the revalidation application.

If a revalidation and change of information application is received concurrently, the contractors shall merge the two applications and process accordingly.

10. Revalidating Providers Involved in a Change of Ownership (CHOW)

Contractors shall not take revalidation actions on providers or suppliers that are undergoing a CHOW that is currently in process by the contractor or pending review by the State/RO. Contractors shall notify their Provider Enrollment Oversight Group (PEOG) Business Function Lead (BFL) if a seller enrollment record is up for revalidation and the CHOW application is currently in process by the contractor. Contractors shall include the seller and buyer enrollment record ID in their email notification to their PEOG BFL.

11. Large Group Revalidation Coordination

In addition to providing the finalized revalidation list with contractor confirmed due dates, CMS will provide a list of large groups affected by this notification, including the individual providers reassigning benefits to their group that appear on the 6 month list. Contractors may stagger the large group mailings however they see fit to ensure the group receives notification that providers within their group will be receiving a request to revalidate in the next 7 months. Contractors shall send the notification letter to the Authorized/Delegated Official or the enrollment contact person. Contractors may send the group notices via email utilizing the email addresses provided as part of the CMS list (derived from Section 2 and 13 of PECOS).

Contractors shall indicate **“IMPORTANT: Group Notification of Upcoming Provider Enrollment Revalidation Request”** in the subject line to differentiate this from other emails. Contractors shall use the sample letter provided in Pub. 100-08, Chapter 15, Section 15.24.5.2 to notify the large groups by attaching the letter in the body of the email. The letter should not be included as an attachment to the email or require a password be sent to the provider/supplier to view the email content. Contractors are not required to send a paper copy of the group notice if sent via email. If all of the emails the notice is sent to are returned as undeliverable, paper revalidation notices shall be mailed to the provider/supplier's correspondence and special payment addresses, within the 90 to 105 day timeframe. Contractors do not need to mail a notification if one or a few of the emails are returned as undeliverable, but one or more have been delivered successfully. If the correspondence and special payment address is the same, contractors shall send the second letter to the provider/supplier's practice location address. If the correspondence, practice and special payments address are the same, only one letter shall be sent.

If no email addresses exist in the enrollment record, then contractors shall mail the notice to the group's correspondence address.

Contractors shall include with the notification letter a spreadsheet identifying the individual providers that will be revalidated. The spreadsheet shall contain the Provider's Name, National Provider Identifier (NPI) and Specialty. This information will be provided as part of the list supplied by CMS.

The large group list will contain only those large groups consisting of 200 or more reassignments. Groups with less than 200 reassignments will not appear on the list and are not required to be emailed or mailed a group notification letter; however, all reassignment information will be available at <https://data.cms.gov/revalidation> for providers and suppliers to view.

Contractors shall designate an enrollment analyst for each of the large groups to coordinate revalidation activities. The designated enrollment analyst shall be identified on the group notification letter. The enrollment analysts shall work directly with the group's enrollment contact person or the Authorized/Delegated Official on file.

Contractors shall allow large groups to submit a spreadsheet identifying those providers that are no longer practicing at their group in lieu of submitting CMS-855R termination applications. The spreadsheet shall be accompanied by a letter signed by the Authorized/Delegated Official of the group. This process is only acceptable for large groups who are completing their revalidation and coordinating directly with the contractor.

12. Finalizing the Revalidation Application

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

- A site visit (if applicable to the provider/supplier in question) is requested to be conducted by the National Site Visit Contractor (NSVC)
- The provider/supplier meets all applicable federal regulatory requirements regarding licensure, certification and/or educational requirements, as listed in the Code of Federal Regulations (CFR) and as described in CMS Publication 100-02 for his or her supplier type.
- The provider/supplier's information is revalidated based on the information in PECOS.
- Practice locations continue to be verified; however, there is no need to contact each and every location separately. Verification shall be done with the contact person listed on the application and noted accordingly in the contractor's verification documentation per section 10.4(C) of this chapter.
- The appropriate logging & tracking (L&T) record type and finalization status are identified in PECOS.
- An enrollment record is not marked as revalidated in PECOS if responses have been received for some PTANs yet not all PTANs have been addressed (meaning that no action has been taken on the non-response PTANs, i.e., end-dated). If all PTANs have been addressed (i.e., revalidated, end-dated), the enrollment can be marked as revalidated.

- PECOS and the claims systems remain in sync. The contractor shall not directly update the shared systems without first updating PECOS when processing a revalidation unless instructed otherwise in another CMS directive.
- When processing of the revalidation application is complete, contractors shall issue an approval letter to the contact person or the provider/supplier if a contact person is not listed, via mail, fax, or email. If the provider/supplier has reassignments that were terminated due to non-response, the approval letter shall contain the reassignments that were terminated due to non-response and the effective date of termination (i.e., the revalidation due date or the development due date).

13. Revalidation Reporting

Contractors are no longer required to submit reports on the 5th and 20th of each month for Cycle 2. However, contractors shall maintain internally the method of delivery for the provider/supplier revalidation notices and the date the email or letter was sent. CMS may periodically request ad hoc reporting of this data. The data elements for ad-hoc reporting shall include, but is not limited to the following; revalidation notification delivery date, delivery method, delivery address, deactivation date, provider response date, reactivation date, application finalization date, etc.

14. Revalidation Files Available Online

The revalidation due dates are available at <https://data.cms.gov/revalidation> via the Revalidation look up tool. The tool includes all enrolled providers/suppliers. Those due for revalidation will display a revalidation due date, all other providers/suppliers not up for revalidation will display a “TBD” (To Be Determined) in the due date field. In addition, a crosswalk to the organizations that the individual provider reassigns benefits will also be available at <https://data.cms.gov/revalidation> on the CMS website.

15. Revalidation Extension Requests

Contractors shall only accept extension requests from a provider or supplier that was not given the full seven months advance notice prior to their revalidation due date as a result of the due date list being untimely posted to the CMS website. Contractors shall no longer accept extension requests from the providers or suppliers for any other reason.

If there is a delay in posting the above referenced list, which impacts a provider or supplier receiving the full six month advance notice, the contractor shall accept the provider or supplier’s extension request and grant the provider or supplier an extension up to the full six month period from the date of the list being posted with no impacts to their effective date. contractors shall accept these type of extension requests from the provider or supplier and the requests may be made by the provider or supplier in writing (fax/email permissible) or via phone requested by the individual provider, Authorized/Delegated Official or contact person.

L. Reactivations

1. Form CMS-855 or CMS-20134 Reactivations

a. Limited

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

b. Moderate

Form CMS-855 reactivation applications submitted by providers and suppliers in the “moderate” level of categorical screening – including existing home health agencies and suppliers of durable medical equipment, prosthetics, orthotics and supplies (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.

c. High

Form CMS-855 or Form CMS-20134 reactivation applications submitted by providers and suppliers in the “high” level of categorical screening shall be processed in accordance with the screening procedures for this category. A site visit will therefore be necessary prior to the contractor’s final decision regarding the application.

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

If the contractor approves a provider or supplier’s reactivation application for a Part B non-certified supplier, the reactivation effective date shall be the date the contractor received the application that was processed to completion. Also, upon reactivating billing privileges for a Part B non-certified supplier, the contractor shall issue a new Provider Transaction Access Number (PTAN).

Contractors shall grant retrospective billing privileges in accordance with Section 15.17(B) for reactivating providers and suppliers, unless otherwise stated in this chapter. This includes providers that were deactivated for not responding to a revalidation request.

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

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 10.2.1(F)(10) of this chapter for more information.)

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

To reactivate its billing privileges, a provider or supplier deactivated for failing to timely notify the contractor of a change of information must submit a complete Medicare enrollment application.

5. Reactivations – Miscellaneous Policies

a. Deactivated for longer than one year

In any situation, described either herein or otherwise, if a provider or supplier is deactivated for longer than one year the provider or supplier is ineligible for reactivation

and must complete an application for initial enrollment. An application fee will be assessed as applicable.

b. Previous Withdrawn Status

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

c. Deactivation for Non-Billing

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

d. Reactivation Applications: Contractor Timeliness Standards

For Form CMS-855 or CMS-20134 reactivation applications, the timeliness requirements in Pub. 100-08, Chapter 15, Section 15.6, 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.

M. Revocations

1. Revocations: Background and General Requirements

a. Introduction

Medicare revokes currently enrolled providers and suppliers Medicare billing privileges and corresponding provider/supplier agreements pursuant to the federal regulations at 42 CFR §424.535. A Medicare revocation is a “termination” as defined at 42 CFR §455.101.

Revocation of Medicare billing privileges will not impact a provider or supplier’s ability to submit claims to non-Medicare payers using their National Provider Identifier.

If the contractor determines that a provider or supplier’s billing privileges should be revoked or receives information from PEOG that a provider or supplier’s billing privileges should be revoked, it shall undertake activities to process the revocation, apply the revocation in PECOS, notify the provider, and afford appeal rights. This section includes, but is not limited to, information concerning the contractor’s responsibilities to:

- Preparing a draft revocation letter;
- E-mailing the letter to PEOG via the EnrollmentEscalations@cms.hhs.gov mailbox with additional pertinent information regarding the basis for revocation;
- Receiving PEOG’s determinations and abiding by PEOG’s instructions regarding the case;
- If PEOG authorizes the revocation:

- Revoking the provider's billing privileges back to the appropriate date;
- Establishing the applicable reenrollment bar;
- Updating PECOS to show the length of the reenrollment bar;
- Assessing an overpayment, as applicable; and
- Sending the revocation letter, affording appeal rights, to the provider or supplier via certified mail.

b. Administrative Requirements

This subsection addresses the contractor's administrative requirements pertaining to revocations including time frames, writing revocation draft letters, and seeking PEOG approval prior to sending a determination letter to a provider. Information concerning elements of a revocation and applying a revocation are covered in subsequent subsections.

c. Processing Revocations: Timeframe for Processing of Revocation Actions

If the contractor receives approval from PEOG (or receives an unrelated request from PEOG) to revoke a provider or supplier's billing privileges, the contractor shall complete all steps associated with the revocation no later than 5 business days from the date it received PEOG's approval/request. The contractor shall notify PEOG that it has completed all of the revocation steps no later than 3 business days after these steps have been completed.

d. Notification Letters for Revocations

i. General Information

When a Medicare contractor discovers a basis for revoking a provider or supplier's enrollment under 42 CFR §424.535 - and, if applicable under section 10.4(M) of this chapter, receives approval from PEOG for the revocation - the contractor shall revoke billing privileges and notify the provider or supplier by letter. The revocation letter shall contain:

- A legal (i.e., regulatory) basis for each reason for revocation;
- A clear explanation of why Medicare billing privileges are being revoked, including the facts or evidence that the contractor used in making its determination;
- An explanation of why the provider or supplier does not meet the applicable enrollment criteria;
- The effective date of the revocation (see section 10.4(M)(2)(i)) of this chapter for more information);
- Procedures for submitting a CAP (if revoked under 42 CFR §424.535(a)(1)); and

- Complete and accurate information about the provider or supplier's further appeal rights.

ii. Revocation Letter: One Letter Per Enrollment

A contractor shall issue a unique revocation letter per enrollment. For example, regarding revocation letters for solely owned organizations, when revoking Medicare billing privileges for a physician/non-physician practitioner and their solely owned organization, contractors shall issue **two** revocation letters; one for the individual and the other for the solely owned organization. One letter shall not be issued to convey revoked Medicare billing privileges for both the individual and the solely owned organization.

iii. Elements of a Revocation Letter - General

When drafting a revocation letter the contractor includes the following elements:

- Effective date
- Revocation Reason
When drafting a revocation letter the contractor shall insert the appropriate regulatory basis (e.g., 42 CFR §424.535(a)(1)) into the letter. The contractor shall not use provisions from this chapter as the basis for revocation.
- Reenrollment Bar information
- Information regarding the provider/supplier's appeal rights

iv. Requirements for CMS PEOG's Approval of Revocation Letters

The contractor shall determine, based upon the guidance in this subsection (below) whether to submit its draft revocation letter to CMS' Provider Enrollment Oversight Group (PEOG) for approval, prior to sending such a letter to a provider.

A. When PEOG Approval of Revocation Letter is Necessary

Except as described above and in section 10.4(M)(1)(d)(iv)(B), the contractor shall submit draft revocation letters to the EnrollmentEscalations@cms.hhs.gov mailbox for PEOG to review. PEOG will notify the contractor of the outcome of this review and instruct the contractor how to proceed. The contractor shall obtain PEOG approval prior to sending a revocation letter.

PEOG reviews a contractor's draft revocation letter for technical correctness and to make determinations including, but not limited to, (1) the extent to which the revoked provider's or supplier's other locations are affected by the revocation, (2) the geographic application of the reenrollment bar, and (3) the effective date of the revocation.

The contractor may not alter an approved revocation letter. Altering an approved revocation letter requires submitting the altered letter for a fresh review via the process described above.

The contractor shall not proceed with finalizing the revocation until guidance is received from PEOG. If guidance from PEOG is delayed, contractors shall carve the impacted application(s) out of their timeliness reporting. Contractors shall document and report the impact application in their Monthly Status Reports.

B. When PEOG Approval of Revocation Letter is Unnecessary

The contractor need not obtain prior PEOG approval of the revocation and the revocation letter if the revocation involves any of the following situations:

- §424.535(a)(1) - Situation (a), (c), (d), (e), (g), (h), or (i)
- §424.535(a)(6)
- §424.535(a)(11)

v. Issuing the Revocation Letter to the Provider/Supplier

The contractor shall send revocation letters by USPS Certified Mail.

The contractor shall not send an initial revocation letter via e-mail, but it is acceptable to e-mail a copy of the letter subsequent to the original issuance via USPS Certified Mail.

The contractor shall make sure the letter is dated and mailed on the same business day.

2. Elements of a Revocation

This section addresses elements of a revocation used in a revocation notification letter.

a. Effective Date of a Revocation

Revocation effective dates are based upon the revocation reason. The contractor shall apply an effective date to a revocation based upon the federal regulation at 42 CFR §424.535(g). This regulation requires a Medicare revocation to have an effective date that is either prospective or retroactive.

A prospective revocation becomes effective 30 days after CMS or the CMS contractor mails notice of its determination to the provider or supplier. A retroactive revocation becomes effective on a date that is the same as the effective date for the underlying revocation reason.

i. Revocations with Retroactive Effective Dates

A revocation based upon any one or more of the following reasons carries a retroactive effective date:

- (1) Federal exclusion or debarment;
- (2) Felony conviction as described in 42 CFR §1001.2;
- (3) License suspension or revocation; or
- (4) Determination that the provider or supplier is no longer operational

A revocation based upon any one or more of the reasons above 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.

For example, when a revocation is based on the revocation/suspension of a license, the effective date of the revocation and the date listed on the revocation letter shall be the date of the actual revocation/suspension of the license.

ii. Revocations with Prospective Effective Dates

The contractor shall use a prospective effective date (i.e., the date that is 30 days after CMS or the CMS contractor mails notice of its determination to the provider or supplier) for:

iii. Revocations that are based upon a reason or reasons not included in the above list of revocations with retroactive effective dates.

For example, for revocations based upon 42 CFR 424.535(a)(8) abuse of billing, the effective date shall be 30 days after the notice of revocation is issued.

iv. Revocations Based Upon More than One Reason

When a revocation is based upon more than one reason, the contractor shall determine whether any of the reasons are included in the list of revocations with retroactive effective dates; and, if so, the contractor shall apply the appropriate retroactive date.

b. Revocation Reasons

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

The provider or supplier is determined not to be in compliance with the enrollment requirements in subpart P (of Part 424) or in the enrollment application applicable to its provider or supplier type, and has not submitted a plan of corrective action as outlined in 42 CFR Part 488. The provider or supplier may also be determined not to be in compliance if it has failed to pay any user fees as assessed under part 488 of this chapter.

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 §424.535(a)(1) may be used as a revocation reason include, but are not limited to, the following:

- The provider or supplier does not have a physical business address or mobile unit where services can be rendered.
- The provider or supplier does not have a place where patient records are stored to determine the amounts due such provider or other person.

- The provider or supplier is not appropriately licensed.
- The provider or supplier is not authorized by the federal/state/local government to perform the services that it intends to render.
- The provider or supplier does not meet CMS regulatory requirements for the specialty that it is enrolled as.
- The provider or supplier does not have a valid social security number (SSN) or employer identification number (EIN) for itself, an owner, partner, managing organization/employee, officer, director, medical director, and/or authorized or delegated official.
- The provider or supplier fails to furnish complete and accurate information and all supporting documentation within 60 calendar days of the provider 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. (This revocation reason will not be used in these cases if CMS has explicitly instructed the contractor to use deactivation reason §424.540(a)(3) in lieu thereof.)
- The provider or supplier does not otherwise meet general enrollment requirements.

With respect to the last bullet above – and, as applicable bullets 3, 4 and 5 – the contractor's revocation letter shall cite the appropriate statutory and/or regulatory citation(s) containing the specific licensure/certification/authorization requirement(s) for that provider or supplier type. For a listing of some of these statutes and regulations, refer to section 10.4(M)(2) et seq. of this chapter.

Certified Providers

Certified providers and suppliers can be involuntarily terminated by the Centers for Medicare & Medicaid Services (CMS) Regional Offices (ROs) if the provider or supplier no longer meets CMS requirements, conditions of participation, or conditions of coverage. When this occurs, the CMS RO terminates the provider's or supplier's Provider Agreement and issues a Tie-Out Notice (Form CMS-2007) to the contractor that informs them that the Agreement is terminated.

Upon receipt of a Tie-Out notice from the RO, communicating an involuntary termination, contractors shall follow revocation procedures in the chapter and revoke the certified provider's or supplier's Medicare billing privileges under 42 CFR §424.535(a)(1). The contractor shall not process the involuntary termination of a certified provider as a deactivation based upon a voluntary withdrawal from Medicare.

The issuance of the Tie-Out for non-compliance of CMS enrollment requirements, conditions of participation, or conditions of coverage provides sufficient basis for the contractor to proceed with a revocation. The contractor is not required to contact the RO to obtain further details of the termination.

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

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 CMS PEOG Business Function Lead (PEOG BFL) immediately. PEOG will notify the Contracting Officer's Representative (COR) for the appropriate Unified Program Integrity Contractor (UPIC). The COR will, in turn, contact the Office of Inspector General's (OIG's) office with the findings for further investigation.

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

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

- (i) 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.
- (ii) 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.
- (iii) 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.
- (iv) Any felonies that would result in mandatory exclusion under section 1128(a) of the Act.
- (v) 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.

The expiration of a re-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.

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

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

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

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

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

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

- (i) An institutional provider does not submit an application fee or hardship exception request that meets the requirements set forth in §424.514 with the Medicare revalidation application; or
- (ii) The hardship exception is not granted and the institutional provider does not submit the applicable application form or application fee within 30 days of being notified that the hardship exception request was denied.
- (iii) Either of the following occurs:
 - CMS is not able to deposit the full application amount into a government-owned account; or
 - The funds are not able to be credited to the United States Treasury;
- (iv) The provider or supplier lacks sufficient funds in the account at the banking institution whose name is imprinted on the check or other banking instrument to pay the application fee; or
- (v) There is any other reason why CMS or its Medicare contractor is unable to deposit the application fee into a government-owned account.

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

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

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

Abuse of billing privileges includes either of the following:

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

- Where the beneficiary is deceased.
- The directing physician or beneficiary is not in the state or country when services were furnished.
- When the equipment necessary for testing is not present where the testing is said to have occurred.

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

- The percentage of submitted claims that were denied.
- The reason(s) for the claim denials.
- Whether the provider or supplier has any history of final adverse actions (as that term is defined in §424.502) and the nature of any such actions.
- The length of time over which the pattern has continued.
- How long the provider or supplier has been enrolled in Medicare.
- Any other information regarding the provider or supplier's specific circumstances that CMS deems relevant to its determination as to whether the provider or supplier has or has not engaged in the pattern or practice described in this paragraph.

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

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

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

With respect to Revocation Reason 9:

- If the provider or supplier reports a change in practice location more than 30 days after the effective date of the change, the contractor shall not pursue a revocation on this basis. However, if the contractor independently determines – through an on-site inspection under 42 CFR §424.535(a)(5)(ii) or via another verification process - that the 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 pursue a revocation (e.g., seeking PEOG's approval to revoke).

- If an IDTF reports a change in ownership, change of location, change in general supervision or change in adverse legal actions more than 30 days after the effective date of the change, the contractor may pursue a revocation on this basis (e.g., seeking PEOG's approval to revoke).
- If a supplier of Durable Medical Equipment, Prosthetics, Orthotics and Suppliers (DMEPOS) reports any changes of information more than 30 days after the effective date of the changes, the contractor may pursue a revocation on this basis (e.g., seeking PEOG's approval to revoke).

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

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

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

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).

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

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

(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).

CMS considers the following factors listed in 42 CFR §424.535(a)(12): (A) The reason(s) for the termination or revocation; (B) Whether the provider or supplier is currently terminated, revoked or otherwise barred from more than one program (for example, more than one State's Medicaid program) or has been subject to any other sanctions during its participation in other programs, and; (C) Any other information that CMS deems relevant to its determination.

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

- (i) The physician or eligible professional's Drug Enforcement Administration (DEA) Certificate of Registration is suspended or revoked; or
- (ii) The applicable licensing or administrative body for any state in which the physician or eligible professional practices suspends or revokes the physician or eligible professional's ability to prescribe drugs.

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

CMS determines that the physician or eligible professional has a pattern or practice of prescribing Part D drugs that falls into one of the following categories:

- (i) The pattern or practice is abusive or represents a threat to the health and safety of Medicare beneficiaries or both.
- (ii) The pattern or practice of prescribing fails to meet Medicare requirements.

CMS considers the following factors listed in 42 CFR §424.535(a)(14): (A) Whether there are diagnoses to support the indications for which the drugs were prescribed; (B) Whether there are instances when the necessary evaluation of the patient for whom the drug was prescribed could not have occurred (for example, the patient was deceased or out of state at the time of the alleged office visit); (C) Whether the physician or eligible professional has prescribed controlled substances in excessive dosages that are linked to patient overdoses; (D) The number and type(s) of disciplinary actions taken against the physician or eligible professional by the licensing body or medical board for the State or States in which he or she practices, and the reason(s) for the action(s); (E) Whether the physician or eligible professional has any history of “final adverse actions” (as that term is defined in §424.502); (F) The number and type(s) of malpractice suits that have been filed against the physician or eligible professional related to prescribing that have resulted in a final judgment against the physician or eligible professional or in which the physician or eligible professional has paid a settlement to the plaintiff(s) (to the extent this can be determined); (G) Whether any State Medicaid program or any other public or private health insurance program has restricted, suspended, revoked, or terminated the physician or eligible professional's ability to prescribe medications, and the reason(s) for any such restriction, suspension, revocation, or termination, and; (H) Any other relevant information provided to CMS.

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

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

The provider or supplier has an existing debt that CMS appropriately refers to the United States Department of Treasury.

CMS considers the following factors listed in 42 CFR §424.535(a)(17): (i) The reason(s) for the failure to fully repay the debt (to the extent this can be determined); (ii) Whether the provider or supplier has attempted to repay the debt (to the extent this can be determined); (iii) Whether the provider or supplier has responded to CMS' requests for payment (to the extent this can be determined); (iv) Whether the provider or supplier has any history of final adverse actions or Medicare or Medicaid payment suspensions; (v) The amount of the debt, and; (vi) Any other evidence that CMS deems relevant to its determination.

NOTE: With respect to (a)(17), PEOG – rather than the contractor – will make all determinations regarding whether a provider or supplier has an existing debt that has been referred to the Department of Treasury.

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

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

- Owning and managing organizations and individuals (regardless if the organizations or individuals are disclosed on the CMS-855 or CMS-20134 application);
- Geographic location;
- Provider or supplier type;
- Business structure; or
- Any evidence that the two parties (the revoked provider or supplier and newly-enrolling provider or supplier) are similar or that the provider or supplier was created to circumvent the revocation or re-enrollment bar.

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

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

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

- (1) The duration of the affiliation.
- (2) Whether the affiliation still exists and, if not, how long ago it ended.
- (3) The degree and extent of the affiliation.
- (4) If applicable, the reason for the termination of the affiliation.
- (5) Regarding the affiliated provider's or supplier's disclosable event under paragraph (b) of this section:
 - (i) The type of disclosable event.
 - (ii) When the disclosable event occurred or was imposed.
 - (iii) Whether the affiliation existed when the disclosable event occurred or was imposed.
 - (iv) If the disclosable event is an uncollected debt:
 - (A) The amount of the debt.

(B) Whether the affiliated provider or supplier is repaying the debt.

(C) To whom the debt is owed.

(v) If a denial, revocation, termination, exclusion, or payment suspension is involved, the reason for the disclosable event.

An affiliation is defined as:

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

NOTE: With respect to (a)(19), PEOG -- rather than the contractor -- will make all determinations regarding whether a provider or supplier has an affiliation per 42 CFR §424.519 that poses an undue risk of fraud, waste and abuse.

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

The provider or supplier billed for services performed at or items furnished from a location that it knew or should have known did not comply with Medicare enrollment requirements. The provider or supplier's Medicare enrollment or enrollments may be revoked even if all of the practice locations associated with a particular enrollment comply with Medicare enrollment requirements. In making its determination, CMS considers the following factors:

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

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

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

The physician or eligible professional has a pattern or practice of ordering, certifying, referring or prescribing Medicare Part A or B services, items or drugs that is abusive, represents a threat to the health and safety of Medicare beneficiaries or otherwise fails to meet Medicare requirements. In making its determination, CMS considers the following factors:

- Whether the physician or eligible professional’s diagnosis supports the order, certification, referral or prescription in question;
- Whether there are instances where the necessary evaluation of the patient for whom the order, certification, referral or prescription could have not occurred (for example: the patient was deceased or out of state at the time of the alleged office visit);
- The number and types of disciplinary actions taken against the physician or eligible professional by the licensing body or medical board for the state(s) in which he or she practices and the reason(s) for the action(s);
- Whether the physician or eligible professional has any history of final adverse actions (as defined by 42 CFR §424.502);
- The length of time over which the pattern or practice has continued;
- How long the physician or eligible professional has been enrolled in Medicare;
- The number of type(s) of malpractice suits that have been filed against the physician or eligible professional related to ordering, certifying, referring or prescribing that resulted in a final judgement against the physician or eligible professional or the physician or eligible professional paid a settlement to the plaintiff(s) (to the extent this can be determined);
- Whether any State Medicaid Agency (SMA) or other public health insurance program has restricted, suspended, revoked or terminated the physician’s or eligible professional’s ability to practice medicine and reason for any such restriction, suspension, revocation or termination; and
- Any other information that CMS deems relevant to its determination.

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

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

The physician or eligible professional has been subject to prior action from a State oversight board, Federal or State health care program, Independent Review Organization (IRO) determination(s), or any other equivalent governmental body or program that oversees, regulates, or administers the provision of health care with underlying facts reflecting improper physician or other eligible professional conduct that led to patient

harm. In determining whether a revocation is appropriate, CMS considers the following factors:

- The nature of the patient harm.
- The nature of the physician's or other eligible professional's conduct.
- The number and type(s) of sanctions or disciplinary actions that have been imposed against the physician or other eligible professional by the State oversight board, IRO, Federal or State health care program, or any other equivalent governmental body or program that oversees, regulates, or administers the provision of health care. Such actions include, but are not limited to in scope or degree:
 - License restriction(s) pertaining to certain procedures or practices.
 - Required compliance appearances before State medical board members.
 - License restriction(s) regarding the ability to treat certain types of patients (for example, cannot be alone with members of a different gender after a sexual offense charge).
 - Administrative or monetary penalties.
 - Formal reprimand(s).
 - If applicable, the nature of the IRO determination(s).
 - The number of patients impacted by the physician's or other eligible professional's conduct and the degree of harm thereto or impact upon.

This section does not apply to actions or orders pertaining exclusively to either of the following:

- Required participation in rehabilitation or mental/behavioral health programs; or
- Required abstinence from drugs or alcohol and random drug testing.

c. Extension of Revocation

If a provider's or supplier's Medicare enrollment is revoked under section 10.4(M) of this chapter, CMS may revoke any and all of the provider's or supplier's Medicare enrollments, including those under different names, numerical identifiers or business identities and those under different types.

In determining whether to revoke a provider's or supplier's other enrollments, CMS considers the following factors:

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

d. Re-enrollment Bar

i. Background

As stated in 42 CFR §424.535(c), if a provider, supplier, owner, or managing employee has 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. The re-enrollment bar begins 30 days after CMS or its contractor mails notice of the revocation and lasts a minimum of 1 year, but not greater than 10 years, depending on the severity of the basis for revocation. In addition, CMS may impose a re-enrollment bar of up to 20 years if the provider or supplier is being revoked from Medicare for the second time.

Per §424.535(c), the re-enrollment 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 re-enrollment bar will be applied.

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 through 10 as well as a 20-year period. Re-enrollment bars that exceed 3 years will be determined by PEOG, rather than the contractor.

In addition, CMS may add up to 3 more years to the provider's or supplier's reenrollment bar if it determines that the provider or supplier is attempting to circumvent its existing reenrollment bar.

ii. Establishment of Length

The following serves merely as general, non-binding guidance regarding the establishment of the length of reenrollment bars. It is crucial to note that every situation must and will be judged on its own merits, facts, and circumstances, and it should not be assumed that a particular timeframe will always be applied to a specific revocation reason in all cases. CMS retains the discretion to apply a reenrollment bar period that is different from that indicated below (though which in no case will be greater than 10 to 20 years).

- §424.535(a)(1) (Noncompliance) -- For licensure issues, 1 year if no billing after loss of license
- §424.535(a)(6) (Grounds Related to Screening) – 1 year
- §424.535(a)(11) (Initial Reserve Operating Funds) – 1 year

Revocation reasons §424.535(a)(17) (Debt Referred to the United States Department of Treasury), §424.535(a)(18) (Revoked Under a Different Name, Numerical Identifier or Business Identity), §424.535(a)(19) (Affiliation that Poses an Undue Risk), §424.535(a)(20) (Billing from a Non-Compliant Location, §424.535(a)(21) (Abusive Ordering, Certifying, Referring, or Prescribing of Part A or B Services, Items or Drugs) and §424.535(a)(22) (Patient Harm) will receive re-enrollment bar lengths per CMS' discretion.

iii. Applicability of Bar

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 not 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.

e. Representing Provider Enrollment Appeals Process in a Revocation Letter

In the revocation letter, the contractor shall include information concerning a provider/supplier's appeal rights. The following table summarizes where a Corrective Action Plan (CAP) and/or Reconsideration Request must be sent.

| | CAP requests should be sent to: | | Reconsideration request should be sent to: | |
|--|--|--------------------------|---|--------------------------|
| Revocation Regulation | Institutional * | Non-institutional | Institutional* | Non-institutional |
| 424.535(a)(1) related to an enrollment requirement (i.e., 425.516) | Alone or in combination: CMS | MAC | CMS | MAC |
| 424.535(a)(1) Licensure | CAP rights (to CMS) | CAP rights (to the MAC) | CMS | MAC |
| 424.535(a)(1) DME or IDTF | CAP rights (to CMS) | CAP rights (to the MAC) | CMS | MAC |
| 424.535(a)(2) Exclusion | No CAP rights | No CAP rights | CMS | CMS |
| 424.535(a)(2) Debarment | No CAP rights | No CAP rights | CMS | CMS |
| 424.535(a)(3) | No CAP rights | No CAP rights | CMS | CMS |
| 424.535(a)(4) | No CAP rights | No CAP rights | CMS | CMS |
| 424.535(a)(5) | No CAP rights | No CAP rights | CMS | MAC |

| | | | | |
|----------------|---------------|---------------|-----|-----|
| 424.535(a)(6) | No CAP rights | No CAP rights | CMS | MAC |
| 424.535(a)(7) | No CAP rights | No CAP rights | CMS | CMS |
| 424.535(a)(8) | No CAP rights | No CAP rights | CMS | CMS |
| 424.535(a)(8) | No CAP rights | No CAP rights | CMS | CMS |
| 424.535(a)(9) | No CAP rights | No CAP rights | CMS | MAC |
| 424.535(a)(10) | No CAP rights | No CAP rights | CMS | CMS |
| 424.535(a)(11) | No CAP rights | No CAP rights | CMS | CMS |
| 424.535(a)(12) | No CAP rights | No CAP rights | CMS | CMS |
| 424.535(a)(13) | No CAP rights | No CAP rights | CMS | CMS |
| 424.535(a)(14) | No CAP rights | No CAP rights | CMS | CMS |
| 424.535(a)(17) | No CAP rights | No CAP rights | CMS | CMS |
| 424.535(a)(18) | No CAP rights | No CAP rights | CMS | CMS |
| 424.535(a)(19) | No CAP rights | No CAP rights | CMS | CMS |
| 424.535(a)(20) | No CAP rights | No CAP rights | CMS | CMS |
| 424.535(a)(21) | No CAP rights | No CAP rights | CMS | CMS |
| 424.535(a)(22) | No CAP rights | No CAP rights | CMS | CMS |

*Institutional providers:

- Ambulatory Surgery Centers
- CLIA Labs
- Community Mental Health Center
- Comprehensive Outpatient Rehabilitation Facilities (CORFs)
- Critical Access Hospitals
- End Stage Renal Disease (ESRDs)
- Federally Qualified Health Careers (FQHCs)
- Histocompatibility Laboratories
- Home Health Agencies
- Hospices
- Hospitals and Hospital Units
- Independent Diagnostic Testing Facilities (IDTFs)
- Indian Health Service Facility
- Mammography Screening Centers
- Mass Immunization/Flu Roster Billers
- Medicare Diabetes Prevention Program (MDPP) Suppliers
- Opioid Treatment Centers (OTPs)
- Organ Procurement Organizations (OPOs)
- Outpatient Physical Therapy/Outpatient Speech Pathology Services (OPT/OSP)

- Pharmacies
- Portable X-Ray Suppliers (PXRSSs)
- Rehabilitation Services
- Religious Non-Medical Health Care Institutions (RNCHIs)
- Rural Health Clinics (RHCs)
- Skilled Nursing Facilities (SNFs)

CMS has defined "institutional provider" to mean any provider or supplier that submits a paper Medicare enrollment application using the CMS-855A, CMS-855B (except physician and non-physician practitioner organizations), or CMS-855S or the associated Internet-based PECOS enrollment application.

For more information regarding the provider enrollment appeals process, see Pub. 100-08, Chapter 15, Section 15.25.

3. Revocations: Other Policies

a. Revocation and Claims: submission of Claims for Services Furnished Before Revocation

Per 42 CFR §424.535(h), a revoked provider or supplier (other than a home health agency (HHA)) must, within 60 calendar days after the effective date of revocation, submit all claims for items and services furnished before the date of the revocation letter. A revoked HHA must submit all claims for items and services within 60 days after the later of: (1) the effective date of the revocation, or (2) the date that the HHA's last payable episode ends.

Nothing in 42 CFR §424.535(h) impacts the requirements of § 424.44 regarding the timely filing of claims.

b. Revocations Based Upon Not Meeting Reporting Requirements

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.

c. 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, CMS will provide a monthly revoked and denied provider list to all contractors via the Share Point Ensemble site. The contractor shall access this list on the 5th day of each month through the Share Point Ensemble site. The contractor shall review the monthly revoked and denied provider list for the names of Medicare providers

revoked and denied in PECOS. The contractor shall document any appeals actions a provider/supplier may have submitted subsequent to the provider or supplier's revocation or denial.

The contractor shall update the last three columns on the tab named "Filtered Revocations" of the spreadsheet for every provider/supplier revocation or denial action taken. The contractor 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 appeals 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 the CGI Share Point Ensemble site.

d. Revocations of Certified Providers and Certified Suppliers: Special Instructions

Section 10.4.1(M)(3)(d) describes the contractor's required action to revoke the enrollment of a certified provider/supplier that is involuntarily terminated by the RO.

The contractor need not obtain prior approval from the state/RO prior to revoking a certified provider or certified supplier's billing privileges. When revoking the provider/supplier, however, the contractor shall:

- E-mail a copy of the revocation letter to the applicable RO's Division of Survey & Certification corporate mailbox. (The RO will notify the state of the revocation.)

- After determining the effective date of the revocation, end-date the entity's enrollment record in the Provider Enrollment, Chain and Ownership System (PECOS) in the same manner as it would upon receipt of a tie-out notice from the RO.
- Afford the appropriate appeal rights per Pub. 100-08, Chapter 15, Section 15.25.

e. Opting-Out After Revocation

Providers who are revoked from Medicare will not be able to order, certify or prescribe Part A or B Services, items, or drugs to Medicare beneficiaries if they opt-out of Medicare after revocation.

For example, if Dr. Thompson is revoked from Medicare, he will not be able to opt-out and order back and knee orthoses for his patients.

f. Overpayments Based Upon Revocations

The contractor shall initiate procedures to collect overpayment after the timeframe for the appeal of the revocation has expired or within 10 days of the final appeal determination at the first level of appeal. Overpayments are processed in accordance with 42 CFR 405 Subpart C.

In situations where a revocation is made with a prospective (i.e., 30 days from the date of CMS or the contractor's mailing of the revocation notification letter to the provider) effective date, the contractor's shall assess an overpayment back to a date that is the more recent of the following:

- The date when Medicare claims are determined to be ineligible for payment; or,
- The date that is within 4 years from the date of the initial claim determination or redetermination for good cause as defined in 42 CFR §405.986 (42 CFR §405.980).

The date when Medicare claims are determined to be ineligible for payment may, but will not always, match the inactive date of the enrollment that is reflected in PECOS and MCS or FISS. Again, the starting date upon which claims are not eligible for reimbursement is what the contractor shall use to determine an overpayment, not the date the enrollment is inactive according to PECOS and MCS or FISS.

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 a date that is the more recent of the following:

- The date of the final adverse action or change in practice location; or,
- The date that is within 4 years from the date of the initial claim determination or redetermination for good cause as defined in 42 CFR §405.986 (42 CFR §405.980).

4. Sources of Identified Revocations

When CMS directs the contractor to take a revocation action, such direction is communicated to the contractor directly from CMS PEOG. This section describes how a subset of potential

revocation actions are identified. Regarding these potential revocations, a contractor takes action to revoke a provider based upon approval or technical direction from PEOG (i.e., Zone Program Integrity Contractor or RO personnel may not direct a contractor to revoke a provider).

a. Unified Program Integrity Contractor (UPIC) Identified Revocations

If, through its investigations, the UPIC believes that a particular provider's or supplier's Medicare billing privileges should be revoked, it shall develop a case file - including the reason(s) for revocation - and submit the file and all supporting documentation to the Provider Enrollment & Oversight Group (PEOG). The UPIC shall provide PEOG with the information described in (2) below.

PEOG will review the case file and:

- Return the case file to UPIC for additional development, or
- Consider approving the UPIC's recommendation for revocation.

If PEOG approves the revocation recommendation, PEOG will: (1) ensure that the applicable contractor is instructed to revoke the provider's/supplier's Medicare enrollment, and (2) notify the applicable contracting officer's representative (COR) in the Division of Medicare Integrity Contractor Operations of the action taken.

If the contractor receives a direct request from a UPIC to revoke a provider's or supplier's Medicare enrollment, it shall refer the matter to its Provider Enrollment Oversight Group (PEOG) Business Function Lead (BFL) if it is unsure whether the UPIC received prior PEOG approval for the revocation.

b. CMS Field Office or Regional Office Identified Revocations

If a CMS field office (SO) or regional office (RO) believes that the use of Revocation Reason 8 (see 42 CFR §424.535(a)(8) is appropriate), the FO/RO will develop a case file - including the reason(s) for revocation - and submit the file and all supporting documentation to PEOG. The case file must include the name, all known identification numbers - including the National Provider Identifier and associated Provider Transaction Access Numbers - and locations of the provider or supplier, as well as detailed information to substantiate the revocation action.

If PEOG concurs with the FO/RO's revocation recommendation, PEOG will: (1) instruct the contractor to revoke the provider/supplier's Medicare billing privileges, and (2) notify the FO/RO of same.

In regards to involuntary termination of certified provider/supplier, Section 10.4(M)(3)(d) of this chapter describes the contractor's required action to revoke the enrollment of a certified provider/supplier that is involuntarily terminated by the RO.

c. U.S. Department of Health & Human Services Office of Inspector General (HHS OIG) Identified Revocations

Actions based on HHS OIG Identified Revocations are the responsibility of PEOG.

d. MDPP Supplier Revocation for Use of an ineligible coach

i. General Procedures

42 CFR §424.205(h)(v) established a new revocation reason specifically for MDPP suppliers for a specific circumstance in which the MDPP supplier knowingly permitted an ineligible coach to furnish MDPP services to beneficiaries, despite being previously removed from the MDPP supplier's roster through a CAP.

If a contractor or UPIC suspects this scenario, it shall develop a case file - including the reason(s) - and submit the file and all supporting documentation to the Provider Enrollment & Oversight Group (PEOG). The contractor shall provide PEOG with the information described in (2) below.

PEOG will review the case file and:

- Return the case file to the contractor for additional development, or
- Consider approving the contractor's recommendation for revocation.

If PEOG approves the revocation recommendation, PEOG will: (1) ensure that the applicable Medicare Administrative Contractor (contractor) is instructed to revoke the provider's/supplier's Medicare enrollment, and (2) notify the applicable contracting officer's representative (COR) in the Division of Medicare Integrity Contractor Operations of the action taken.

If the contractor receives a direct request from a UPIC to revoke a provider's or supplier's Medicare enrollment, it shall refer the matter to its PEOG Business Function Lead (PEOG BFL) if it is unsure whether the UPIC received prior PEOG approval for the revocation.

ii. Revocation Request Data

The revocation request shall contain the following information:

- Provider/supplier name; administrative location(s); community setting(s) if applicable type (e.g., DMEPOS supplier); Provider Transaction Access Number; National Provider Identifier; applicable Medicare Administrative Contractor
- Name(s), e-mail address(es), and phone number(s) of investigators
- Tracking number
- Provider/supplier's billing status (Active? Inactive? For how long?)
- Whether the provider/supplier is a Fraud Prevention System provider/supplier
- Source/Special Project
- Whether the provider/supplier is under a current payment suspension
- Legal basis for revocation

- Relevant facts
- Application of facts to revocation reason
- Any other notable facts
- Effective date (per 42 CFR § 424.535(g))
- Supporting documentation
- Photos (which should be copied and pasted within the document)

iii. Effective Dates

If revoked under this authority, the MDPP supplier does not have CAP rights. The revocation becomes effective 30 days after the contractor sends notice of the revocation.

iv. Reenrollment Bar

As stated in 42 CFR §424.205(h), if an MDPP supplier, owner, or managing employee has 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. The re-enrollment bar begins 30 days after CMS or its contractor mails notice of the revocation and lasts a minimum of 1 year, but not greater than 3 years, depending on the severity of the basis for revocation.

v. Processing information

Refer to 10.4(M)(1)(a) and 10.4(M)(3)(a)(i) for additional processing information that also apply to this revocation reason.

N. Deactivations

1. Reasons

Unless indicated otherwise in this chapter or in another CMS instruction or directive, the contractor shall – without prior approval from its CMS Provider Enrollment Business Function Lead (PEBFL) - deactivate a provider or supplier's entire enrollment record and Medicare billing privileges when:

- A provider or supplier fails to respond to a revalidation request;
- A provider or supplier fails to respond timely to a revalidation development request,
- A provider is enrolled in an approved status without an active reassignment or practice location for 90 days or longer, or
- A provider deactivates an EFT Agreement and remains enrolled but does not submit a new EFT agreement within 90 days.

The contractor shall not take deactivation actions unless specified in this chapter or other CMS directives.

2. Regulations

- 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; a provider or supplier fails to report a change in ownership or control within 30 calendar days.
- Per §424.540(a)(3), a provider or supplier does not furnish complete and accurate information and all supporting documentation within 90 calendar days of receipt of notification from CMS to submit an enrollment application and supporting documentation, or resubmit and certify to the accuracy of its enrollment information.

3. Effective Dates

The effective dates of a deactivation are as follows:

- a. Non-Billing §424.540(a)(1) – The effective date is the date the action is taken unless stated otherwise in this chapter or another CMS directive.
- b. Failure to Report or Furnish Information §424.540(a)(2) and (3), – The effective date is the date the action is taken unless stated otherwise in this chapter or another CMS directive.
- c. The “36-Month Rule” for HHAs – CMS’ provider enrollment staff will determine the effective date during its review of the case.

4. Rebuttal Rights

A provider or supplier whose Medicare billing privileges have been deactivated may file a rebuttal to challenge the deactivation. See Pub. 100-08, Chapter 15, Section 15.27.5 for further instruction.

5. Miscellaneous

- a. The deactivation of Medicare billing privileges does not affect a supplier's participation agreement (CMS-460).
- b. 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 PEBFL for review and approval. The only exception for PEBFL review and approval is deactivations due to failure to comply with a revalidation request.

10.6.19 – Other Medicare Contractor Duties

(Rev. 10723; Issued: 04-08-21; Effective: 07-27-20; Implementation: 08-10-20)

The contractor shall adhere to all of the instructions in this chapter 10 (hereafter generally referred to as “this chapter”) and all other CMS provider enrollment directives (e.g., Technical Direction letters). The contractor shall also assign the appropriate number of staff to the Medicare enrollment function to ensure that all such instructions and directives - including application processing timeframes and accuracy standards - are complied with and met.

A. Training

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

- An overview of the Medicare program
- A review of all applicable regulations, manual instructions, and other CMS guidance
- A review of the contractor’s enrollment processes and procedures
- Training regarding the Provider Enrollment, Chain and Ownership System (PECOS).

For new employees, the contractor shall also:

- Provide side-by-side training with an experienced provider enrollment analyst
- Test the new employee to ensure that he or she understands Medicare enrollment policy and contractor processing procedures, including the use of PECOS
- Conduct end-of-line quality reviews for 6 months after training or until the analyst demonstrates a clear understanding of Medicare enrollment policy, contractor procedures, and the proper use of PECOS.

For existing employees, periodic quality reviews and refresher trainings shall be performed by the contractor on a periodic basis.

B. PECOS

The contractor shall:

- Process all enrollment actions (e.g., initials, changes, revalidations, revocations, appeals, denials) through PECOS
- Deactivate or revoke the provider or supplier’s Medicare billing privileges in the Multi-Carrier System or the Fiscal Intermediary Shared System only if the provider or supplier is not in PECOS, if the provider does not exist in MCS or FISS, prior to taking action contact CMS
- Close or delete any aged logging and tracking (L & T) records older than 120 days for which there is no associated enrollment application

- Participate in user acceptance testing for each PECOS release
- Attend scheduled PECOS training when requested
- Report PECOS validation and production processing problems through the designated tracking system for each system release
- Develop (and update as needed) a written training guide for new and current employees on the proper processing of Form CMS-855, CMS-20134 applications, opt out affidavits, and the appropriate entry of data into PECOS.

C. Customer Service

1. Responding to Provider Enrollment Inquiries

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

- Application status checks (e.g., "Has the contractor finished processing my application?") (The contractor may wish to establish electronic mechanisms by which providers can obtain updates on the status of their enrollment applications via the contractor's Web site or automated voice response (AVR).
- Furnishing information on where to access the Form CMS-855 or CMS-20134 applications (and other general enrollment information) on-line
- Explaining to providers/suppliers which Form CMS-855 or CMS-20134 applications should be completed.

2. Contractor's Responsiveness to Inquiries

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

D. Contractor Outreach to Providers

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

E. Encouraging Use of Internet-based PECOS

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

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

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

1. Background

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

Should the audit and claims contractors differ, the audit contractor shall process all changes of information, including all Form CMS-588 changes. The audit contractor shall notify the applicant during the initial enrollment process that all future changes of information must be sent to the audit contractor, not the claims contractor. If the provider inadvertently sends a change request to the claims contractor, the latter shall return the application per section 10.4(H)(1) of this chapter.

2. Process

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

- (a) Send an e-mail to the claims contractor identifying the specific Form CMS-855A transaction involved and confirming that the information has been updated in the Provider Enrollment, Chain and Ownership System (PECOS). Pertinent identifying information, such as the provider name, CMS Certification Number and National Provider Identifier, shall be included in the e-mail notification. If the e-mail contains any supporting documentation that contains personal health information or personally identifiable information the audit contractor shall encrypt the e-mail prior to sending.
- (b) As applicable, fax, mail, or email an encrypted copy of the submitted Form CMS-588 to the appropriate claims contractor.

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

The audit contractor shall keep all original copies of Form CMS-855A paperwork and supporting documentation, including all Form CMS-588s.

3. Tie-In/Tie-Out Notices and Approval Notices

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

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

G. Online Presence – Web Sites

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

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

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

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/contact_list.pdf

If the contractor services several States with a universal address and telephone number, the contractor shall report that information. In situations where no actions are required, a response from the contractor is still required (i.e., the contact information is accurate). In addition, only such information that pertains to provider enrollment activity for the contractor's jurisdiction is

to be reported. All updates shall be sent directly via e-mail to the contractor's CMS PEOG Business Function Lead (BFL).

H. Document Retention

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

Supporting documentation includes, but is not limited to:

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

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

1. Provider/Supplier and Durable Medical Equipment Supplier Application

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

Disposition: Destroy when 7 years old.

b. Approved applications of provider/supplier

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

c. Denied applications of provider/supplier.

Disposition: Destroy 15 years after the date of denial.

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

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

e. Voluntary deactivation of billing number

Disposition: Destroy 15 years after deactivation.

f. Provider/Supplier dies

Disposition: Destroy 7 years after date of death.

2. Electronic Mail and Word Processing System Copies

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

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

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

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

I. Keeping Record of Activities

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

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

J. Keeping Record of Written and Telephonic Communications

(For purposes of this section 10.6.19(H), “written correspondence” includes mailed, faxed, and e-mailed correspondence.)

K. Keeping Record of Written Correspondence

The contractor shall:

- Retain copies of all written correspondence pertaining to the provider, regardless of whether the correspondence was initiated by the contractor, the provider, CMS, State officials, etc.
- Document when it sends written correspondence to providers. For instance, if the contractor crafts an approval letter to the supplier dated March 1 but sends it out on March 3, the contractor shall note this in the file.
- Document all referrals to CMS, the UPIC, or the OIG

L. Keeping Record of Telephonic or Face-to-Face Contact

Telephonic or Face-to-Face Contact is hereafter referred to as “oral communication.”

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

- Telephoning a provider about its application. (Even if the provider official was unavailable and a voice mail message was left, this must be documented.)
- Requesting information from the state or another contractor concerning the applicant or enrollee
- Contacting the UPIC for an update concerning a particular case
- Phone calls from the provider
- Conducting a meeting at the contractor’s headquarters/offices with officials from a hospital concerning problems with its application
- Telephoning PEOG or the RO (e.g., the RO’s survey and certification staff) and receiving instructions therefrom about a problem the contractor is having with an applicant or an existing provider
- Telephoning the provider’s billing department with a question about the provider.

When documenting oral communications, the contractor shall indicate: (1) the time and date of the call or contact; (2) who initiated the contact; (3) who was spoken with; and (4) what the conversation pertained to. Concerning the last requirement, the contractor need not write down every word that was said during the conversation. Rather, the documentation should merely be adequate to reflect the contents of the conversation. The documentation can be crafted and stored electronically if the contractor can provide access within 24 hours upon request.

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

If an application is returned per section 10.4(H)(1) of this chapter, the contractor shall document this. The manner of documentation lies within the contractor’s discretion.

M. Documenting Verification of Data Elements

Once the contractor has completed its review of the CMS-855, CMS-20134 applications,(e.g., approved/denied application, approved change request) and Opt Out Affidavits, it shall document that it has: (1) verified all data elements on the application, and (2) reviewed all applicable names on the above mentioned forms against the OIG/LEIE and the System for

Access Management (SAM). It can be drafted in any manner the contractor chooses so long as it certifies that the above-mentioned activities were completed. The record can be stored electronically.

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

N. Release of Information

On October 13, 2006, CMS published System of Records Notice for the Provider Enrollment, Chain and Ownership System (PECOS) in the Federal Register. Consistent with this notice, once the provider has submitted an enrollment application (as well as after it has been enrolled), the contractor shall not release – either orally or in writing - provider-specific data to any outside person or entity, unless specified otherwise in this chapter. (Provider-specific data includes, but are not limited to, owners/managers, adverse legal history, practice locations, group affiliations, effective dates, etc.) Examples of outside persons or entities include, but are not restricted to, national or state medical associations or societies, clearinghouses, billing agents, provider associations, or any person within the provider's organization other than the provider's authorized official(s) (section 15 of the CMS-855 and CMS-20134), delegated official(s) (section 16), or contact persons (section 13). The only exceptions to this policy are:

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

(These provisions also apply in cases where the provider requests a copy of any Form CMS-855 or CMS-20134 paperwork the contractor has on file.)

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

- The following information shall be made available over-the-phone to a caller who is able to provide a provider/suppliers name, PTAN, TIN/SSN and NPI number. The caller does not need to be listed on the provider/supplier's enrollment record as a contact person:
- Revalidation status (i.e., whether or not a provider/supplier has been revalidated),
- Revalidation due date,
- Revalidation approval date,
- The specific information related to a revalidation development request, and

- The date a provider/supplier was deactivated due to non-response to a revalidation or non-response to a development request.

In addition:

- When sending emails, the contractor shall not transmit sensitive data, such as social security numbers or employer identification numbers, without first encrypting the email.
- The contractor may not send PECOS screen printouts to the provider.
- With the exception of CMS-855S applications, if any contact person listed on a provider or supplier's enrollment record, requests a copy of a provider or supplier's Medicare approval letter or revalidation notice, the contractor shall send to the contact person via email, fax or mail. This excludes Certification Letters (Tie In notices), as the contractor is not responsible for generating these approvals.

O. Security

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

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

All contractor staff shall be trained on security procedures as well as relevant aspects of the Privacy Act and the Freedom of Information Act. This applies to all management, users, system owners/managers, system maintainers, system developers, operators and administrators - including contractors and third parties - of CMS information systems, facilities, communication networks and information.

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

P. Contractor to Contractor Communications

Medicare contractors create Associate and Enrollment Records in the Provider Enrollment, Chain and Ownership System (PECOS). Ownership of an Associate or Enrollment Record belongs to the contractor within whose jurisdiction the provider/supplier is located. PECOS only permits the contractor that created the Associate or Enrollment Record (the "owning contractor") to make updates, changes, or corrections to those records. (That is, the owning contractor is the only contractor that can make changes to the associate record.)

Occasionally, updates, changes, or corrections do not come to the owning contractor's attention, but instead go to a different contractor. In those situations, the contractor that has been notified of the update/change/correction (the "requesting" contractor) must convey the changed information to the owning contractor so that the latter can update the record in PECOS.

The requesting contractor may notify the owning contractor via fax or email (encrypted if it contains personally identifiable information) of the need to update/change/correct information in a provider's PECOS record. The notification must contain:

1. The provider's legal business name, Provider Transaction Access Number, and National Provider Identifier; and
2. The updated/changed/corrected data (by including a copy of the appropriate section of the Form CMS-855 or CMS-20134).

Within 7 calendar days of receiving the requesting contractor's request for a change to a PECOS record, the owning contractor shall make the change and notify the requesting contractor thereof via fax, e-mail, or telephone.

If the owning contractor is reluctant to make the change, it shall contact its CMS Provider Enrollment & Oversight Group (PEOG) BFL for guidance. Note that the owning contractor may ask the requesting contractor for any additional information about the provider it deems necessary (e.g., IRS documentation, licenses).

The owning contractor need not ask the provider for a Form CMS-855 or CMS-20134 change of information in associate profile situations. It can simply use the Form CMS-855 or CMS-20134 copy that the requesting contractor sent/faxed to the owning contractor. For instance, suppose Provider X is enrolled in two different contractor jurisdictions – A and B. The provider enrolled with "A" first; its legal business name was listed as "John Brian Smith Hospital." It later enrolls with "B" as "John Bryan Smith Hospital." "B" has verified that "John Bryan Smith Hospital" is the correct name and sends a request to "A" to fix the name. "A" is not required to ask the provider to submit a Form CMS-855A change of information. It can use the CMS-855A copy that it received from "B."

Q. Establishment of Relationships

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

R. Ongoing Monitoring Activities: Monitoring Information from State Licensing Boards

To help ensure that only qualified physicians and non-physician practitioners are enrolled in Medicare, the contractor shall undertake the activities described below.

For purposes of this section, the term "practitioner" includes both physicians and non-physician practitioners. In addition, the instructions in this section, apply only to these practitioners.

Regarding monthly reviews, no later than the 15th day of each month, the contractor shall review State licensing board information for each State within its jurisdiction to determine whether any of its currently enrolled practitioners have, within the previous 60 days:

- Had their medical license revoked, suspended or inactivated (due to retirement, death, or voluntary surrender of license);

- Otherwise lost their medical license or have had their licenses expire.
- For those practitioners who no longer have a valid medical license, the contractor shall take the necessary steps pursuant to guidance in this chapter.
- The mechanism by which the contractor shall perform these monthly licensure reviews lies within its discretion, though the most cost-effective method shall be used.

S. Regarding Potential Identity Theft or Other Fraudulent Activity

In conducting the verification activities described in section 10.6.19(H) of this chapter, 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 CMS Provider Enrollment & Oversight Group Business Function Lead (PEOG BFL) immediately; the BFL will instruct the contractor as to what, if any, action shall be taken,

10.5- Timeliness and Accuracy Standards

(Rev. 10727; Issued: 04-13-21; Effective: 02-01-21; Implementation: 02-01-21)

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

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

- Receipt of the application or opt-out affidavit in the contractor's mailroom and forwarding it to the appropriate office for review.
- Prescreening the application or opt-out affidavit.
- Creating a logging and tracking (L & T) record and an enrollment or opt-out affidavit record in the Provider Enrollment, Chain and Ownership System (PECOS).
- Ensuring that the information on the application or opt-out affidavit is verified.
- Requesting and receiving clarifying information.
- Site visit (if necessary).
- Requesting fingerprints (if necessary).
- Formal notification to the SA and/or RO of the contractor's approval, denial or recommendation for approval of the application.

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

For purposes of Sections 10.5(A) and 10.5(B) below:

- The term “site visit” means that the provider or supplier requires an on-site review to determine that the provider or supplier is operational based on the type of provider or supplier.
- The term “development” means that the contractor needs to contact the provider or supplier for additional information; A development request (via letter, fax, email or telephone contact for development) to the provider or supplier is considered to be the first development request.
- The term “fingerprinting” means that 5 percent or greater owners or partners of a provider or supplier is required to submit fingerprints for an additional level of screening.

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

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

- Form CMS-855 or Form CMS-20134 change of ownership, acquisition/merger, and consolidation applications submitted by the new owner.
- “Complete” Form CMS-855 or Form CMS-20134 applications submitted by enrolled providers: (a) voluntarily, (b) as part of any change request if the provider does not have an established enrollment record in the Provider Enrollment, Chain and Ownership System (PECOS), or (c) as a Form CMS- 855 or Form CMS-20134 reactivation.
- Opt-out affidavits submitted for an eligible practitioner’s first opt-out period.

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

- Form CMS-855 and Form CMS-20134 change of ownership, acquisition/merger, and consolidation applications submitted by the old owner
- Form CMS-588 changes submitted without a need for an accompanying complete Form CMS-855 or Form CMS-20134 application
- Form CMS-855R applications submitted independently (i.e., without being part of a Form CMS-855I or Form CMS-855B package)
- Form CMS-855 and Form CMS-20134 voluntary terminations
- Opt-out early termination requests (of initial opt-out affidavits), changes of information and cancellation requests

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

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

Please refer to Section 10.5 above for definitions of site visits, development and fingerprinting.

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

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

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

The contractor shall process 95 percent of all Form CMS-855 and Form CMS- 20134 initial and change of information applications and opt-out affidavits (initials, changes of information, termination and cancellation requests) that do not require a site visit, development and/or fingerprinting within 30 calendar days of receipt and process 100 percent of all Form CMS-855 and Form CMS-20134 initial and change of information applications and opt-out affidavits (initials, changes of information, termination and cancellation requests) that do not require a site visit, development and/or fingerprinting within 65 calendar days of receipt.

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

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

3. Web-Based Initial and Change of Information Applications - Timeliness

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

a. Web-Based Initial and Change of Information Applications That Require a Site Visit, Development and/or Fingerprinting

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

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

The contractor shall process 95 percent of Form CMS-855 and Form CMS-20134 Web-based initial and change of information applications that do not require a site visit, development and/or fingerprinting within 15 calendar days of receipt and process 100 percent of Form CMS-855 and Form CMS-20134 Web-based initial and change of information applications that do not require a site visit, development and/or fingerprinting within 50 calendar days of receipt.

4. Web-Based Initial and Change of Information Applications - Accuracy

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

B. Standards for Revalidation Applications

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

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

Please refer to Section 10.5 above for definitions of site visits, development and fingerprinting.

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

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

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

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

2. Paper Revalidation Applications - Accuracy

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

3. Web-Based Revalidation Applications - Timeliness

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

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

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

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

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

4. Web-Based Revalidation Applications - Accuracy

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

C. General Timeliness Principles

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

1. Clock Stoppages

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

- Referring an application to the Office of Inspector General (OIG) or the Unified Program Integrity Contractor (UPIC).
- Waiting for a final sales agreement (e.g., CHOW, acquisition/merger).
- Contacting the CMS regional office (RO) and/or State Agency (SA) regarding a provider-based or CHOW determination or the RO's survey and certification staff with a question regarding the application of a CMS policy or contact to a State Agency (SA).
- Referring a provider or supplier to update their information in the National Plan & Provider Enumeration System.
- Contacting CMS' Provider Enrollment & Oversight Group (PEOG) for the following reasons: questions regarding the application, CMS policy, an Adverse Legal Action review, affiliations/overpayments found on the monthly report or PECOS, Advanced Provider Screening criminal alerts, or delayed site visits (for A/B MACs and the NSC).
- Referring a provider to the Social Security Administration to resolve a discrepancy involving a social security number or to the Internal Revenue Service to resolve a Tax Identification Number or Individual Tax Identification Number issue.
- Contact to another MAC for any type of PECOS update (i.e.: locked associates).
- Contact to the PECOS Maintainer for resolutions to system issues (i.e.: RightNow tickets).
- Practice location and Special Payment address changes and specialty changes with future dates.
- If fingerprints are required, the timeliness clock stops when the fingerprint request is issued and resumes when the contractor receives the results (if additional information is developed at the same time as the fingerprint request is issued, no action shall be taken on the developed information until after the fingerprint results are received).

Should a dependent application be needed to continue processing (for example: a CMS-855R is needed to complete a reassignment when only a CMS-855I is received), contractors shall apply a clock stoppage when the development is issued and resume the timeliness clock once the development is received.

Contractors should always document any delays by identifying when the referral to CMS, the OIG, etc., was made, the reason for the referral, and when a response was received. By doing so, the contractor will be able to furnish explanatory documentation to CMS should applicable time limits be exceeded. To illustrate, assume that a contractor received an initial Form CMS-855I application on March 1. On March 30, the contractor sent a question to CMS, and received a reply on April 7. The processing time clock stops from March 31 to April 7. The contractor should document its files to explain that it forwarded the question to CMS, the dates involved, and the reason for the referral.

2. Calendar Days

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

3. Date-Stamping

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

- Any Form CMS-855 or Form CMS-20134 application, including initials, changes, CHOWs, etc. (The first page of the application must be date-stamped.)
- Letters from providers. (The first page of the letter must be date-stamped.)
- Supporting documentation, such as licenses, certifications, articles of incorporation, and billing agreements. (The first page of the document or the envelope must be date-stamped.)
- Data that the provider furnishes (via mail or fax) per the contractor’s request for additional information. (All submitted pages must be date-stamped. This is because many contractors interleaf the new/changed pages within the original application. Thus, it is necessary to determine the sequence in which the application and the additional pages were received.)

Note: applications received via Internet-Based PECOS are considered “date stamped” on the date the application was received, which is reflected as part of the applications’ Logging and Tracking (L&T) ID.

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

In addition, and unless stated otherwise in this chapter or in another CMS directive, all incoming enrollment applications (including change requests) must be submitted via mail (unless circumstances require submission via fax or email, as noted in Section 10.4(D)(6)(a) of this chapter).

4. When the Processing Cycle Ends

For (1) Form CMS-855A applications, and (2) Form CMS-855B applications submitted by ambulatory surgical centers (ASCs) or portable x-ray suppliers, the processing cycle ends on the date that the contractor enters a final status (approval or denial recommended) in PECOS,

rather than the date that the contractor sends formal notification to the SA or CMS RO of the contractor's approval, denial or recommendation for approval of the application (note that accompanying applications, such as CMS-855R applications submitted along with a CMS-855B for an ASC, would also end their processing cycle).

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

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

5. PECOS

The contractor may begin the verification process at any time. Also, the contractor is not required to create a PECOS logging and tracking (L&T) at any specific time, though an L&T record must be created in order to enter and finalize the application in PECOS.

Moreover, the contractor must establish a complete enrollment record in PECOS prior to its approval, recommendation of approval, or denial of the provider's application. To the maximum extent possible, the contractor shall establish the enrollment record at one time, rather than on a piecemeal basis.

10.6 -Additional Topics Pertaining to Medicare Enrollment (Rev. 10524; Issued: 12-17-20; Effective: 11-13-20; Implementation: 11-13-20)

A. Changes of Ownership (CHOWs)

Unless otherwise stated, all references to the "RO" in sections 10.6(A) through 10.6(C) of this chapter refer to the RO's survey & certification staff.

Changes of ownership (CHOWs) are officially defined in and governed by 42 CFR §489.18 and Publication 100-07, chapter 3, sections 3210 through 3210.5(C). The RO – not the contractor – makes the determination as to whether a CHOW has occurred (unless this function has been delegated).

Unless specified otherwise, the term "CHOW" - as used in sections 10.6(A) through 10.6(C) of this chapter - includes CHOWs, acquisitions/mergers and consolidations.

Though the Change of Ownership (CHOW) Information section of the Form CMS-855A separates the applicable transactions into CHOWs, acquisition/mergers and consolidations for ease of disclosing and reporting, they fall within the general CHOW category under 42 CFR §489.18 (e.g., an acquisition/merger is a type of CHOW under §489.18).

1. Definitions for CHOWs

For purposes of provider enrollment only, there are three main categories of CHOWs captured on the Form CMS-855A application:

a. “Standard” CHOW

This occurs when a provider’s CMS Certification Number (CCN) and provider agreement are transferred to another entity as a result of the latter’s purchase of the provider. To illustrate, suppose Entity A is enrolled in Medicare, but Entity B is not. B acquires A. Assuming all regulatory requirements are met, A’s provider agreement and CCN number will transfer to B.

This is the most frequently encountered change of ownership scenario. As explained in section 10.6(A), even though it is technically an acquisition (i.e., B bought/acquired A) under § 489.18, this situation falls under the “CHOW” category – as opposed to the “Acquisition/Merger” category – on the Form CMS-855A.

b. Acquisition/Merger

In general, this occurs when two or more Medicare-enrolled entities combine, leaving only one remaining CCN number and provider agreement. For instance, Entity A and Entity B are both enrolled in Medicare, each with its own CCN number and provider agreement. The two entities decide to merge. Entity B’s CCN number and provider agreement will be eliminated (leaving only Entity A’s CCN number and provider agreement).

If the acquisition results in an existing provider having new owners but keeping its existing provider number, the applicant should check the CHOW box in the Basic Information section of the Form CMS-855A.

Unlike the new owner in a CHOW or consolidation, the new owner in an acquisition/merger need not complete the entire Form CMS-855A. This is because the new owner is already enrolled in Medicare. As such, the provider being acquired should be reported as a practice location in the Practice Location Information section of the new owner’s Form CMS-855A.

c. Consolidations

This occurs when the merger of two or more Medicare-enrolled entities results in the creation of a brand new entity. To illustrate, if Entities A and B decide to combine and, in the process, create a new entity (Entity C), the CCN numbers and provider agreements of both A and B will be eliminated. Entity C will have its own CCN number and provider agreement.

Note the difference between acquisitions/mergers and consolidations. In an acquisition/merger, when A and B combine there is one surviving entity. In a consolidation, when A and B combine there are no surviving entities. Rather, a new entity is created – Entity C.

Under 42 CFR §489.18(a)(4), the lease of all or part of a provider facility constitutes a change of ownership of the leased portion. If only part of the provider is leased, the original provider agreement remains in effect only with respect to the un-leased portion. (See Publication 100-07, chapter 3, section 3210.1D (4) for more information.)

Note that a provider may undergo a financial or administrative change that it considers to be a CHOW, but does not meet the regulatory definition identified in §489.18.

2. Examining Whether a CHOW May Have Occurred: CMS Form-855A

As stressed in section 10.6(A), the RO – not the contractor – determines whether a CHOW has occurred (unless this function has been delegated). However, in processing the application, the contractor shall perform all necessary background research regarding whether: (1) a CHOW may have occurred, and/or (2) the new owner is accepting assignment of the Medicare assets and liabilities of the old owner. Such research may include reviewing the sales agreement or lease agreement, contacting the provider(s) to request clarification of the sales agreement, etc. (A CHOW determination by the RO is usually not required prior to the contractor making its recommendation.)

While a CHOW is usually accompanied by a tax identification number (TIN) change, this is not always the case. There may be isolated instances where the TIN remains the same. Conversely, there may be cases where a provider is changing its TIN but not its ownership. In short, while a change of TIN (or lack thereof) is evidence that a CHOW may or may not have occurred, it is not the most important factor; rather, the change in the provider's ownership arrangement is. Hence, the contractor should review the sales/lease agreement closely, as this will help indicate whether a CHOW may or may not have occurred.

In addition:

(a) If the provider claims that the transaction in question is a stock transfer and not a CHOW, the contractor reserves the right to request any information from the provider to verify this (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 may have 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) There may be instances where the contractor enters a particular transaction into the Provider Enrollment, Chain and Ownership System (PECOS) as a CHOW, but it turns out that the transaction was not a CHOW (e.g., was a stock transfer; was an initial enrollment because the new owner refused to accept the Medicare liabilities). If the contractor cannot change the transaction type in PECOS, it can leave the record in a CHOW status; however, it should note in the provider's file that the transaction was not a CHOW.

3. CMS-855A: Processing CHOW Applications

Unless stated otherwise in this chapter, the contractor shall ensure that all applicable sections of the Form CMS-855A for both the old and new owners are completed in accordance with the instructions on the Form CMS-855A.

a. Previous Owner(s)

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

If the previous owner's Form CMS-855A is available at the time of review, the contractor shall examine the information therein against the new owner's Form CMS-855A to ensure

consistency (e.g., same names). If the previous owner's Form CMS-855A has not been received, the contractor shall contact the previous owner and request it. However, the contractor may begin processing the new owner's application without waiting for the arrival of the previous owner's application. It may also make its recommendation to the State agency without having received the previous owner's Form CMS-855A. The contractor, of course, shall not make a recommendation for approval unless the new owner has checked on the form that it will assume the provider agreement and the terms of the sales agreement indicate as such.

If a certification statement is not on file for the previous owner, the contractor shall request that the Individual Ownership and/or Managing Control section be completed for the individual who is signing the certification statement.

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

b. New Owner(s)

If a Form CMS-855A is not received from the new owner within 14 calendar days of receipt of the previous owner's Form CMS-855A, the contractor shall contact the new owner. If the new owner fails to: (1) submit a Form CMS-855A and (2) indicate that it accepts assignment of the provider agreement, within 30 calendar days after the contractor contacted it, the contractor shall stop payments unless the sale has not yet taken place per the terms of the sales agreement. Payments to the provider can resume once this information is received and the contractor ascertains that the provider accepts assignment.

c. Order of Processing

To the maximum extent practicable, Form CMS-855A applications from the previous and new owners in a CHOW should be processed as they come in. The contractor should not wait for applications from both the previous and new owner to arrive before processing them. However, unless the instructions in this chapter indicate otherwise, the contractor should attempt to send the previous and new owners' applications to the State simultaneously, rather than as soon as they are processed. For instance, suppose the previous owner submits an application on March 1. The contractor should begin processing the application immediately, without waiting for the arrival of the new owner's application. Yet it should avoid sending the previous owner's application to the State until the new owner's application is processed. (For acquisition/mergers and consolidations, the contractor may send the applications to the RO separately, since one number is going away.)

d. Sales and Lease Agreements

The contractor shall abide by the following:

- **Verification of Terms** - The contractor shall determine whether: (1) the sales/lease agreement includes the signatures of the buyer and seller and the information contained within is consistent with that reported on the new owner's Form CMS-855A (e.g., same names, effective date), and (2) the terms of the contract indicate that the new owner will assume the provider agreement. In many cases, the sales/lease agreement will not

specifically refer to the Medicare provider agreement. Clearly, if the box in the Change of Ownership (CHOW) Information section is checked "Yes" and the sales/lease agreement either confirms that the new owner will assume the agreement or is relatively silent on the matter, the contractor can proceed as normal. Conversely, if the agreement indicates that the assets and liabilities will not be accepted, the contractor should deny the application.

- **Form of Sales/Lease Agreement** - There may be instances where the parties in a CHOW did not sign a "sales" or "lease" agreement in the conventional sense of the term; the parties, for example, may have documented their agreement via a "bill of sale." The contractor may accept this documentation in lieu of a sales/lease agreement so long as the document furnishes clear verification of the terms of the transaction and the information is consistent with that contained in the 855A as discussed above.
- **Submission of Final Sales/Lease Agreement** - The contractor shall not forward a copy of the application to the State agency until it has received and reviewed the final sales/lease agreement. It need not revalidate the information on the Form CMS-855A, even if the data therein may be somewhat outdated by the time the final agreement is received.

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

Unless specified otherwise in this chapter, both the previous and new owners must submit separate Form CMS-855A applications, as well as copies of the interim and final sales/lease agreements.

e. CHOWs Involving Subtypes

On occasion, a CHOW may occur in conjunction with a change in the facility's provider subtype. This frequently happens when a hospital undergoes a CHOW and changes from a general hospital to another type of hospital, such as a psychiatric hospital. Although a change in hospital type is considered a change of information (COI), it is not necessary for the provider to submit separate applications – one for the COI and one for the CHOW. Instead, all information (including the change in hospital type) should be reported on the CHOW application; the entire application should then be processed as a CHOW. However, if the facility is changing from one main provider type to another (e.g., hospital converting to a skilled nursing facility) and also undergoing a CHOW, the provider must submit its application as an initial enrollment.

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

f. Early Submission of CHOW Application

The contractor may accept Form CMS-855A CHOW applications submitted up to 30 calendar days prior to the anticipated date of the ownership change. Any application

received more than 30 days before the projected sale date can be returned under section 10.4(H)(1) of this chapter.

g. Unreported CHOW

If the contractor learns via any means that an enrolled provider has: (1) been purchased by another entity, or (2) purchased another Medicare enrolled provider, the contractor shall immediately request Form CMS-855A applications from both the previous and new owners. If the new owner fails to submit a Form CMS-855A within the latter of: (1) the date of acquisition, or (2) 30 days after the request, the contractor shall stop payments to the provider. Payments may be resumed upon receipt of the completed Form CMS-855A.

If the contractor learns of the transaction via the receipt of a tie-in notice from the RO, it shall follow the instructions under “Receipt of Tie-In When CMS-855A Not Completed” in section 10.6(B)(2)(a) of this chapter.

h. Relocation of Entity

A new owner may propose to relocate the provider concurrent with the 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 provider shall - per CMS Publication 100-07, chapter 3, section 3210.1(B)(5) - treat the transaction as an initial enrollment (and the provider as a new applicant), rather than as an address change of the existing provider.

i. Transitioning to Provider-Based Status

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

j. Intervening Change of Ownership (CHOW)

This section does not apply to home health agencies.

In situations where (1) the provider submits a Form CMS-855A initial application or CHOW application and (2) a CMS-855A CHOW application is subsequently submitted but before the contractor has received the tie-in notice from the CMS Regional Office (RO), the contractor shall abide by the following:

- Situation 1 – The provider submitted an initial application followed by a CHOW application, and a recommendation for approval has not yet been made with respect to the initial application – The contractor shall return both applications and require the provider to re-submit an initial application with the new owner’s information.
- Situation 2 - The provider submitted a CHOW application followed by another CHOW

application, and a recommendation for approval has not been made for the first application - The contractor shall process both applications – preferably in the order in which they were received – and shall, if recommendations for approval are warranted, refer both applications to the State/RO in the same package. The accompanying notice/letter to the State/RO shall explain the situation.

- Situation 3 - The provider submitted an initial application followed by a CHOW application, and a recommendation for approval of the initial application has been made – The contractor shall:
 - Return the CHOW application.
 - Notify the State/RO via letter (sent via mail or e-mail) that there has been a change of ownership (the new owner should be identified) and that the contractor will be requiring the provider to resubmit a new initial application containing the new owner's information.
 - Request via letter that the provider submit a new initial CMS-855A application containing the new owner's information within 30 days of the date of the letter. If the provider fails to do so, the contractor shall return the initial application and notify the provider and the State/RO of this via letter. If the provider submits the application, the contractor shall process it as normal and, if a recommendation for approval is made, send the revised application package to the State/RO with an explanation of the situation; the initially submitted application becomes moot. If the newly submitted application is denied, however, the initially submitted application is denied as well; the contractor shall notify the provider and the State/RO accordingly.
- Situation 4 - The provider submitted a CHOW application followed by another CHOW application, and a recommendation for approval has been made for the first application - The contractor shall:
 - Notify the State/RO via e-mailed letter that there has been a change of ownership (the new owner should be identified) and that the contractor will be requiring the provider to resubmit a new initial application containing the new owner's information.

Process the new CHOW application as normal. If a recommendation for approval is made, the contractor shall send the revised CHOW package to the State/RO with an explanation of the situation; the first CHOW application becomes moot. If the newly submitted CHOW application is denied, the first application is denied as well; the contractor shall notify the provider and the State/RO accordingly.

4. Examining Whether a CHOW May Have Occurred- Form CMS-855B (applicable only to portable x-ray suppliers, and ASCs)

a. Review of Sales Agreement

If the "Change of Ownership" box in the Basic Information section 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:

- The ownership change qualifies as a CHOW under the principles of 42 CFR §489.18 and Pub. 100-07, chapter 3, section 3210.1D;
- Its terms indicate that the new owner will be accepting assignment of the Medicare assets and liabilities of the old owner;
- The information contained in the agreement is consistent with that reported on the new owner's Form CMS-855B (e.g., same names, effective date)

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 (requirement 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 and the information is consistent with that contained in the 855B as discussed above in requirement 3.
- 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 10.4(H)(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:

- i. 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.
- ii. 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.
- iii. 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 final 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 30 days after the contractor’s receipt of the new owner’s application, the contractor shall reject the application. Though the contractor must wait until the 30th day to reject the application, the contractor may 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 the new owner will or will not be accepting assignment as well as the assets and liabilities of the old owner, the contractor shall enter the CHOW information into the new enrollment record that shall be created for the CHOW buyer. 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 in the new owner's enrollment record once the record is switched to an approved status.

If the CHOW is for a Part B Certified Supplier, a new enrollment record must be created if a new Tax ID is created in the CHOW.

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. 100-07, 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.

5. Electronic Funds Transfer (EFT) Payments and CHOWs

In a CHOW, the contractor shall continue to pay the old owner until it receives the tie-in/approval notice from the RO. Hence, any application from the old or new owner to change the EFT account or special payment address to that of the new owner shall be rejected. It is the responsibility of the old and new owners to work out any payment arrangements between themselves while the contractor and RO are processing the CHOW. It is advisable that the contractor notify the new owner of this while the application is being processed.

In a CHOW, the existing provider agreement is automatically assigned to the Buyer/Transferee. If the Buyer/Transferee does not explicitly reject automatic assignment before the transfer date, the provider agreement is automatically assigned, along with the CCN, effective on the transfer date. The assigned agreement is subject to all applicable statutes and regulations and to the terms and conditions under which it was originally issued. Among other things, this means that the contractor will continue to adjust payments to the provider to account for prior overpayments and underpayments, even if they relate to services provided before the sale/transfer. If the Buyer rejects assignment of the provider agreement, the Buyer must file an initial application to participate in the Medicare program. In this situation, Medicare will **never** pay the applicant for services the prospective provides before the date on which the provider qualifies for Medicare participation as an initial applicant.

Depending on the terms of the sale, the Buyer/Transferee may obtain a new NPI or maintain the existing NPI. After CHOW processing is complete, the Seller/Transferor will no longer be allowed to bill for services (i.e., services furnished after CHOW processing is complete) and only the Buyer is permitted to submit claims using the existing CCN. It is ultimately the responsibility of the old and new owners to work out between themselves any payment arrangements for claims for services furnished during the CHOW processing period.

6. CHOW: Pre-Approval Changes of Information

a. CHOW: Regarding Seller

If – prior to the issuance of the tie-in notice – the contractor receives from the seller a Form CMS-855 request to change any of the provider's enrollment data, the contractor shall reject the change request if the information in question involves changing the provider's:

- i. Electronic funds transfer or special payment address information to that of the buyer (as described in section 10.6(A)(5) of this chapter)
- ii. Practice location or base of operations to that of the buyer
- iii. Ownership or managing control to that of the buyer
- iv. Legal business name, tax identification number, or “doing business as” name to that of the buyer.

All other “pre-tie-in notice” Form CMS-855 change requests from the seller can be processed normally.

b. CHOW: Regarding Buyer

If – prior to the issuance of the tie-in notice – the contractor receives from the buyer a Form CMS-855 request to change any of the provider’s existing enrollment information, the contractor shall reject the change request. Until the tie-in notice is issued, the seller remains the owner of record. Hence, the buyer has no standing to submit Form CMS-855 changes on behalf of the provider.

10.6.1 – Certified Providers/Suppliers

(Rev. 10524; Issued: 12-17-20; Effective: 11-13-20; Implementation: 11-13-20)

A. Background

The Social Security Act (the Act) mandates the establishment of minimum health and safety and CLIA standards that must be met by providers and suppliers participating in the Medicare and Medicaid programs. These standards are found in the 42 Code of Federal Regulations. The Secretary of the Department of Health and Human Services has designated CMS to administer the standards compliance aspects of these programs. For information concerning certification and compliance, including information by provider/supplier type, see the CMS Survey & Certification – Certification & Compliance web page: <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/index.html>.

B. Tie-In Notices

1. Tie-In Notices: General Background

- Although it may vary by regional office (RO), tie-in and tie-out notices are generally issued in the following circumstances:
- Initial enrollment
- Change of Ownership (CHOW) under 42 CFR §489.18
- Acquisition/Merger
- Consolidation

- Addition or deletion of home health agency (HHA) branch, hospital unit, or outpatient physical therapy extension site
- Voluntary termination of billing numbers (unless the voluntary termination is based on situations found in Section 10.4(I)(1) of this chapter)
- Involuntary termination of billing numbers (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.)

If the contractor decides to recommend approval of the provider or supplier's application, the contractor shall send a recommendation letter or email to the applicable State agency, with a copy to the Regional Office's (RO) survey and certification unit.

As each RO may have different practices for issuing tie-in and tie-out notices, the contractor should contact its RO to find out the specific circumstances in which such notices are issued. This also applies to instances where the RO delegates the task of issuing tie-in or tie-out notices 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 latter has indeed delegated this function to the State, and (2) the specific transactions (e.g., CHOWs, HHA branch additions) for which this function has been delegated.

In addition:

- **Approval Letters** – Depending on the RO, an approval letter may be issued in lieu of a tie-in notice.
- **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 CMS-855. If there are discrepancies (e.g., different legal business name, address), the contractor shall contact the RO to determine why the data is different.
- **Receipt of Tie-In When CMS-855 Not Completed** - If the contractor receives a tie-in notice from the RO but the provider never submitted the necessary Form CMS-855 application, the contractor shall immediately alert the RO of the situation. The contractor shall also contact the provider and have it complete and submit the required application. (This applies to initial applications, CHOWs, practice location additions, etc.)
- **Creation of New Logging & Tracking (L & T) Record Unnecessary** - The contractor is not required to create a new L & T record in the Provider Enrollment, Chain and Ownership System when the tie-in notice comes in, as the existing record should not be in a final status and can therefore be modified. Simply changing the L & T status is sufficient.

Note that 42 CFR §489.13 governs the determination of the effective date of a Medicare provider agreement or supplier approval for health care facilities that are subject to survey and certification. Section 489.13 has been revised to state that: (1) the date of a Medicare provider agreement or supplier approval may not be earlier than the latest date on which all applicable federal requirements have been met, and (2) such requirements include the contractor's review and verification of an application to enroll in the Medicare program. (See sections 10.2.1(F)(10) and 10.6.2(G) of this chapter for more information.)

2. Tie-In and Approval Letter Procedures for Form CMS-855A

This section addresses procedures regarding tie-in notices, tie-out notices and approval letters.

a. 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.

b. 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.

c. 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.

d. 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.

e. 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.

f. Timeframes

So as not to keep the PECOS record in "approval recommended" status interminably, if the contractor does not receive notification of approval from the RO after 120 days, it may

contact the RO to see if such approval is forthcoming. The contractor may contact the RO every 30 days thereafter to inquire on the status of the approval until it is received.

g. Processing Tie-In Notices/Approval Letters

With respect to Form CMS-855A transactions for which a post-tie-in notice/approval letter site visit is not required (e.g., providers in the “limited” risk category), 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 provider’s ability to bill Medicare such as, but not limited to:

i. Entering all relevant data into the Provider Enrollment, Chain and Ownership System (PECOS).

ii. Changing the provider’s PECOS record to the appropriate status (e.g., “approved”).

iii. Facilitating the provider’s electronic funds transfer and electronic data interchange arrangements.

iv. Notifying the provider (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-855A 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.

3. Certification and Changes of Information, Stock Transfers, and Other Transactions

A provider or supplier reports Changes of Information, Stock Transfers, and Other Transactions via a Form CMS-855.

a. Provider or Supplier-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-855, the contractor need not ask the provider or supplier to submit a Form CMS-855 change of information.

b. Referrals to State/RO

The following is a list of Form CMS-855A transactions that generally 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 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 transaction. However, if the contractor knows that the particular state/RO in question typically does not review, approve, or deny this type of transaction, the contractor need not send the transaction to the state/RO for approval and shall instead follow the instructions in section 10.6.1(B)(3)(b)(ii) below.

(If the transaction is a stock transfer, the contractor need not send the transaction to the state/RO for approval (and shall instead follow the instructions in section 10.6.1(B)(3)(b)(ii) below) if the following three conditions are met:

- (i) The contractor is confident that the transaction is merely a transfer of stock and not a CHOW,
- (ii) The RO in question (based on the contractor’s past experience with this RO) does not treat stock transfers as potential CHOWs, and
- (iii) The contractor knows that the particular state/RO in question does not review, approve, or deny this type of transaction.

If any of these 3 conditions are not met, the contractor shall send the transaction to the state/RO for approval.

RO approval for the transactions listed in section 10.6.1(B)(3)(b)(i) may be furnished to the contractor via tie-in notice, letter, e-mail, fax, or even telephone; the contractor may accept any of these formats.

If the RO (after receiving the transaction from the contractor for review) notifies the contractor that it does not normally review/approve/deny such transactions, the contractor may finalize the transaction (e.g., switch the PECOS record to “approved”).

c. 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
- The transactions (excluding stock transfers) described in section 10.6.1(B)(3)(b)(i) for which the contractor knows that the state/RO does not issue approvals/denials
- Stock transfers for which the 3 conditions mentioned in section 10.6.1(B)(3)(b)(i) are met
- Voluntary terminations of PTANs

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.

d. All Other Changes of Information

For all Form CMS-855A change requests not identified in section 10.6.1(B)(3)(b)(i) or 10.6.1(B)(3)(b)(ii) 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.

e. Revalidations, Reactivations and Complete Form CMS-855A 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 recommended” only if the application contains new/changed data falling within one of the categories in 10.6.1(B)(3)(b). 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 section 10.6.1(B)(3)(b)(ii), 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.

4. Procedures for Form CMS-855B

This section addresses procedures regarding tie-in notices, tie-out notices and approval letters.

a. 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.

b. 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.

c. 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.

d. 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.

e. 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.

f. Timeframes

So as not to keep the PECOS record in “approval recommended” status interminably, if the contractor does not receive notification of approval from the RO after 120 days, it may contact the RO to see if such approval is forthcoming. The contractor may contact the RO every 30 days thereafter to inquire on the status of the approval until it is received.

5. Procedures Regarding Ambulatory Surgical Centers (ASCs)/Portable X-ray Suppliers (PXR) Tie-In/Tie-Out Notices and Referrals to the State/RO

This section addresses procedures regarding tie-in notices, tie-out notices and approval letters for ASCs and PXR.

For purposes of this section 10.6(B)(1), 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:

- Initial enrollments
- CHOWs
- Voluntary terminations
- Involuntary terminations (e.g., supplier no longer meets conditions of coverage) prompted by the state/RO.

Section 10.4(M)(2)(b)(i)(1) describes the contractor's required action to revoke the enrollment of a certified provider/supplier that is involuntarily terminated by the 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.)

6. Certification and Changes of Information, Stock Transfers, and Other Transactions

A provider or supplier reports Changes of Information, Stock Transfers, and Other Transactions via a Form CMS-855B.

a. Provider or Supplier-Specific, Non-CMS-855 Changes:

In general, 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-855, the contractor need not ask the provider or supplier to submit a Form CMS-855 change of information.

b. 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 transaction. However, if the contractor knows that the

particular state/RO in question typically does not review, approve, or deny this type of transaction, the contractor need not send the transaction to the state/RO for approval and shall instead follow the instructions in (B)(2) below.

(If the transaction is a stock transfer, the contractor need not send the transaction to the state/RO for approval (and shall instead follow the instructions in (B)(2) below) if the following three conditions are met:

- (i) The contractor is confident that the transaction is merely a transfer of stock and not a CHOW,
- (ii) The RO in question (based on the contractor's past experience with this RO) does not treat stock transfers as potential CHOWs, and
- (iii) The contractor knows that the particular state/RO in question does not review, approve, or deny this type of transaction.

If any of these 3 conditions are not met, the contractor shall send the transaction to the state/RO for approval.)

RO approval for the transactions listed in section 10.6.1(B)(6)(c) may be furnished to the contractor via tie-in notice, letter, e-mail, fax, or even telephone; the contractor may accept any of these formats.

If the RO (after receiving the transaction from the contractor for review) notifies the contractor that it does not normally review/approve/deny such transactions, the contractor may finalize the transaction (e.g., switch the PECOS record to "approved).

c. 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
- 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
- The transactions (excluding stock transfers) described in section 10.6.1(B)(6)(c) for which the contractor knows that the state/RO does not issue approvals/denials
- Stock transfers for which the 3 conditions mentioned in section 10.6.1(B)(6)(c) are met.

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.

d. All Other Changes of Information

For all Form CMS-855B change requests not identified in section 10.6.1(B)(6)(c) or 10.6.1(B)(6)(d) 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.

e. Revalidations, Reactivations and Complete CMS-855B Applications

In situations where the provider submits a: (1) Form CMS-855B reactivation, or (2) Form CMS-855B revalidation the contractor shall make a recommendation to the state/RO and switch the record to “approval recommended” 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. 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. The contractor shall adhere to the instructions in section 10.4(M)(2)(b)(ii) of this chapter with respect to revoking the provider’s/supplier’s enrollment, as the supplier is no longer in compliance with Medicare enrollment regulations.

The revocation shall be recorded in PECOS using the status reason of “Non-Compliance: Provider/Supplier Type Requirements Not Met.” Contractors shall not identify the involuntary termination action in PECOS as a Deactivation with a status reason of “Voluntarily Withdrawal from the Medicare Program.”

In addition, contractors shall issue a revocation letter to the certified provider or supplier using 42 CFR §424.535(a)(1), as the legal basis for the revocation. The letter shall also contain the effective date of the revocation, appeal rights and the length of the enrollment bar as determined by CMS and indicated to the contractor. The issuance of the Tie-Out for non-compliance of CMS enrollment requirements, conditions of participation, or conditions of coverage is sufficient to revoke.

10.6.1 – Certified Providers/Suppliers

(Rev. 10345; Issued: 09-11-2020; Effective: 11-13-2020; Implementation: 11-13-2020)

A. Background

The Social Security Act (the Act) mandates the establishment of minimum health and safety and CLIA standards that must be met by providers and suppliers participating in the Medicare and Medicaid programs. These standards are found in the 42 Code of Federal Regulations. The Secretary of the Department of Health and Human Services has designated CMS to administer the standards compliance aspects of these programs. For information concerning certification and compliance, including information by provider/supplier type, see the CMS Survey & Certification – Certification & Compliance web page: <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/index.html>.

B. Tie-In Notices

1. Tie-In Notices: General Background

- Although it may vary by regional office (RO), tie-in and tie-out notices are generally issued in the following circumstances:
- Initial enrollment
- Change of Ownership (CHOW) under 42 CFR §489.18
- Acquisition/Merger
- Consolidation
- Addition or deletion of home health agency (HHA) branch, hospital unit, or outpatient physical therapy extension site
- Voluntary termination of billing numbers (unless the voluntary termination is based on situations found in Section 10.4(I)(1) of this chapter)
- Involuntary termination of billing numbers (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.)

If the contractor decides to recommend approval of the provider or supplier's application, the contractor shall send a recommendation letter or email to the applicable State agency, with a copy to the Regional Office's (RO) survey and certification unit.

As each RO may have different practices for issuing tie-in and tie-out notices, the contractor should contact its RO to find out the specific circumstances in which such notices are issued. This also applies to instances where the RO delegates the task of issuing tie-in or tie-out notices 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 latter has indeed delegated this function to the State, and (2) the specific

transactions (e.g., CHOWs, HHA branch additions) for which this function has been delegated.

In addition:

- **Approval Letters** – Depending on the RO, an approval letter may be issued in lieu of a tie-in notice.
- **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 CMS-855. If there are discrepancies (e.g., different legal business name, address), the contractor shall contact the RO to determine why the data is different.
- **Receipt of Tie-In When CMS-855 Not Completed** - If the contractor receives a tie-in notice from the RO but the provider never submitted the necessary Form CMS-855 application, the contractor shall immediately alert the RO of the situation. The contractor shall also contact the provider and have it complete and submit the required application. (This applies to initial applications, CHOWs, practice location additions, etc.)
- **Creation of New Logging & Tracking (L & T) Record Unnecessary** - The contractor is not required to create a new L & T record in the Provider Enrollment, Chain and Ownership System when the tie-in notice comes in, as the existing record should not be in a final status and can therefore be modified. Simply changing the L & T status is sufficient.

Note that 42 CFR §489.13 governs the determination of the effective date of a Medicare provider agreement or supplier approval for health care facilities that are subject to survey and certification. Section 489.13 has been revised to state that: (1) the date of a Medicare provider agreement or supplier approval may not be earlier than the latest date on which all applicable federal requirements have been met, and (2) such requirements include the contractor's review and verification of an application to enroll in the Medicare program. (See sections 10.2.1(F)(10) and 10.6.2(G) of this chapter for more information.)

2. Tie-In and Approval Letter Procedures for Form CMS-855A

This section addresses procedures regarding tie-in notices, tie-out notices and approval letters.

a. 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.

b. 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.

c. 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.

d. 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.

e. 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.

f. Timeframes

So as not to keep the PECOS record in “approval recommended” status interminably, if the contractor does not receive notification of approval from the RO after 120 days, it may contact the RO to see if such approval is forthcoming. The contractor may contact the RO every 30 days thereafter to inquire on the status of the approval until it is received.

g. Processing Tie-In Notices/Approval Letters

With respect to Form CMS-855A transactions for which a post-tie-in notice/approval letter site visit is not required (e.g., providers in the “limited” risk category), 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 provider’s ability to bill Medicare such as, but not limited to:

i. Entering all relevant data into the Provider Enrollment, Chain and Ownership System (PECOS).

ii. Changing the provider’s PECOS record to the appropriate status (e.g., “approved”).

iii. Facilitating the provider’s electronic funds transfer and electronic data interchange arrangements.

iv. Notifying the provider (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-855A 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.

3. Certification and Changes of Information, Stock Transfers, and Other Transactions

A provider or supplier reports Changes of Information, Stock Transfers, and Other Transactions via a Form CMS-855.

a. Provider or Supplier-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-855, the contractor need not ask the provider or supplier to submit a Form CMS-855 change of information.

b. Referrals to State/RO

The following is a list of Form CMS-855A transactions that generally 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 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 transaction. However, if the contractor knows that the particular state/RO in question typically does not review, approve, or deny this type of transaction, the contractor need not send the transaction to the state/RO for approval and shall instead follow the instructions in section 10.6.1(B)(3)(b)(ii) below.

(If the transaction is a stock transfer, the contractor need not send the transaction to the state/RO for approval (and shall instead follow the instructions in section 10.6.1(B)(3)(b)(ii) below) if the following three conditions are met:

- (i) The contractor is confident that the transaction is merely a transfer of stock and not a CHOW,
- (ii) The RO in question (based on the contractor's past experience with this RO) does not treat stock transfers as potential CHOWs, and
- (iii) The contractor knows that the particular state/RO in question does not review, approve, or deny this type of transaction.

If any of these 3 conditions are not met, the contractor shall send the transaction to the state/RO for approval.

RO approval for the transactions listed in section 10.6.1(B)(3)(b)(i) may be furnished to the contractor via tie-in notice, letter, e-mail, fax, or even telephone; the contractor may accept any of these formats.

If the RO (after receiving the transaction from the contractor for review) notifies the contractor that it does not normally review/approve/deny such transactions, the contractor may finalize the transaction (e.g., switch the PECOS record to "approved").

c. 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
- The transactions (excluding stock transfers) described in section 10.6.1(B)(3)(b)(i) for which the contractor knows that the state/RO does not issue approvals/denials
- Stock transfers for which the 3 conditions mentioned in section 10.6.1(B)(3)(b)(i) are met
- Voluntary terminations of PTANs

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.

d. All Other Changes of Information

For all Form CMS-855A change requests not identified in section 10.6.1(B)(3)(b)(i) or 10.6.1(B)(3)(b)(ii) 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.

e. Revalidations, Reactivations and Complete Form CMS-855A 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 recommended” only if the application contains new/changed data falling within one of the categories in 10.6.1(B)(3)(b). 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 section 10.6.1(B)(3)(b)(ii), 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.

4. Procedures for Form CMS-855B

This section addresses procedures regarding tie-in notices, tie-out notices and approval letters.

a. 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.

b. 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.

c. 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.

d. 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.

e. 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.

f. Timeframes

So as not to keep the PECOS record in “approval recommended” status interminably, if the contractor does not receive notification of approval from the RO after 120 days, it may contact the RO to see if such approval is forthcoming. The contractor may contact the RO every 30 days thereafter to inquire on the status of the approval until it is received.

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

This section addresses procedures regarding tie-in notices, tie-out notices and approval letters for ASCs and PXRSs.

For purposes of this section 10.6(B)(1), 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:

- Initial enrollments
- CHOWs
- Voluntary terminations
- Involuntary terminations (e.g., supplier no longer meets conditions of coverage) prompted by the state/RO.

Section 10.4(M)(2)(b)(i)(1) describes the contractor’s required action to revoke the enrollment of a certified provider/supplier that is involuntarily terminated by the 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.)

6. Certification and Changes of Information, Stock Transfers, and Other Transactions

A provider or supplier reports Changes of Information, Stock Transfers, and Other Transactions via a Form CMS-855B.

a. Provider or Supplier-Specific, Non-CMS-855 Changes:

In general, 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-855, the contractor need not ask the provider or supplier to submit a Form CMS-855 change of information.

b. 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 transaction. However, if the contractor knows that the particular state/RO in question typically does not review, approve, or deny this type of transaction, the contractor need not send the transaction to the state/RO for approval and shall instead follow the instructions in (B)(2) below.

(If the transaction is a stock transfer, the contractor need not send the transaction to the state/RO for approval (and shall instead follow the instructions in (B)(2) below) if the following three conditions are met:

- (i) The contractor is confident that the transaction is merely a transfer of stock and not a CHOW,
- (ii) The RO in question (based on the contractor’s past experience with this RO) does not treat stock transfers as potential CHOWs, and
- (iii) The contractor knows that the particular state/RO in question does not review, approve, or deny this type of transaction.

If any of these 3 conditions are not met, the contractor shall send the transaction to the state/RO for approval.)

RO approval for the transactions listed in section 10.6.1(B)(6)(c) may be furnished to the contractor via tie-in notice, letter, e-mail, fax, or even telephone; the contractor may accept any of these formats.

If the RO (after receiving the transaction from the contractor for review) notifies the contractor that it does not normally review/approve/deny such transactions, the contractor may finalize the transaction (e.g., switch the PECOS record to “approved”).

c. 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
- 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
- The transactions (excluding stock transfers) described in section 10.6.1(B)(6)(c) for which the contractor knows that the state/RO does not issue approvals/denials
- Stock transfers for which the 3 conditions mentioned in section 10.6.1(B)(6)(c) are met.

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.

d. All Other Changes of Information

For all Form CMS-855B change requests not identified in section 10.6.1(B)(6)(c) or 10.6.1(B)(6)(d) 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.

e. Revalidations, Reactivations and Complete CMS-855B Applications

In situations where the provider submits a: (1) Form CMS-855B reactivation, or (2) Form CMS-855B revalidation the contractor shall make a recommendation to the state/RO and switch the record to “approval recommended” 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. 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. The contractor shall adhere to the instructions in section 10.4(M)(2)(b)(ii) of this chapter with respect to revoking the provider's/supplier's enrollment, as the supplier is no longer in compliance with Medicare enrollment regulations.

The revocation shall be recorded in PECOS using the status reason of "Non-Compliance: Provider/Supplier Type Requirements Not Met." Contractors shall not identify the involuntary termination action in PECOS as a Deactivation with a status reason of "Voluntarily Withdrawal from the Medicare Program."

In addition, contractors shall issue a revocation letter to the certified provider or supplier using 42 CFR §424.535(a)(1), as the legal basis for the revocation. The letter shall also contain the effective date of the revocation, appeal rights and the length of the enrollment bar as determined by CMS and indicated to the contractor. The issuance of the Tie-Out for non-compliance of CMS enrollment requirements, conditions of participation, or conditions of coverage is sufficient to revoke.

10.6.1.3 – Voluntary Terminations

(Rev. 10740; Issued: 05-07-21; Effective: 03-26-21; Implementation: 06-07-21)

The CMS Provider Enrollment & Oversight Group (PEOG) and Medicare Administrative Contractors have assumed a number of enrollment-related functions previously handled by state agencies (hereafter occasionally referenced as "state") and CMS Survey & Operations Group Locations (SOG Locations) concerning certified provider and certified supplier voluntary terminations. This section 10.6.1.3 instructs the contractor on how to process such transactions. Unless stated otherwise, these instructions take precedence over those in section 10.4(I) of this chapter.

A. Background – Required Notifications

Consistent with the principles of 42 CFR § 489.52(a) (and except as otherwise required), a certified provider/supplier that wishes to terminate its agreement with Medicare must send written notice of its intention to the SOG Location, the state agency, or the contractor within the timeframes addressed in § 489.52. Under CMS Publication (Pub.) 100-07, chapter 2, section 2005F, the notice is a letter on letterhead with an authorized signature.

Submission of a Form CMS-855 voluntary termination application is not mandatory but is highly preferred. Providers and suppliers are encouraged to continue to submit this form.

Section 10.6.1.3(B) below discusses various scenarios that the contractor may encounter in processing certified provider/supplier voluntary terminations. These should be reviewed and considered in conjunction with the policies in section 10.6.1.3(C) below, particularly those in subsections (C)(2), (C)(3), (C)(6), and (C)(7).

B. Situations and Scenarios

1. Termination Reported to Contractor Via Form CMS-855 or Letter with No Prior Notice from State Agency or SOG Location

If the contractor receives a Form CMS-855 voluntary termination application or a voluntary termination letter (but not both) directly from a certified provider/supplier without having received any termination notification from the state/SOG Location, the following apply:

- (i) The contractor shall: (a) process the application/letter consistent with the timeframes for voluntary terminations in section 10.4(I) of this chapter; and (b) as applicable, follow the instructions in section 10.6.1.3(C) below.*

(NOTE: If the application/letter is from a skilled nursing facility (SNF), the contractor shall contact the state agency to determine whether the SNF is in compliance with the requirements of 42 CFR §§ 483.15(c)(8) and 483.70(l). These two provisions address the SNF's required notice to the state of an impending closure and patient safety. If the state indicates that the SNF is not compliant, the contractor shall contact its Provider Enrollment & Oversight Group Business Function Lead (PEOG BFL) for guidance; if compliance is confirmed, the contractor can proceed as normal.)

- (ii) Prior to finalizing its processing of the Form CMS-855 or letter submission, the contractor shall e-mail a copy of the draft approval letter (see the model letter in section 10.7.20 of this chapter) containing the appropriate termination effective date, reason for termination, and source of the termination notice (i.e., Form CMS-855 or letter) to PEOG at MedicareProviderEnrollment@cms.hhs.gov, with "S&C Voluntary Termination" in the e-mail's subject line.*
- (iii) PEOG will update the Automated Survey Process Environment (ASPEN) system, notify the contractor thereof, and, if the provider/supplier is deemed, provide the contractor the name and e-mail address of the applicable accreditation organization (AO).*
- (iv) Within 3 business days of receiving of the aforementioned notice from PEOG, the contractor shall: (1) e-mail a copy of the final signed approval letter to the provider/supplier, SOG Location, state agency, and AO (if the provider/supplier is deemed); and (2) deactivate the provider/supplier in the Provider Enrollment, Chain and Ownership System (PECOS) pursuant to the instructions/guidance in section 10.6.1.3(C)(9) below.*

2. Termination Reported to Contractor Via Form CMS-855 and Letter with No Prior Notice from State Agency or SOG Location

If the contractor receives a Form CMS-855 voluntary termination application and a voluntary termination letter directly from a certified provider/supplier without having received any termination notification from the state/SOG Location, the following apply:

- (i) If the Form CMS-855 and letter arrive either simultaneously or before the contractor begins processing one of them, the contractor has the discretion to determine which submission to process. It need not process both of them; the submission that the contractor does not process may be returned (consistent with the instructions in this*

chapter) or placed in the provider/supplier file, and the contractor need take no further action thereon.

(ii) If the contractor receives both submissions and it has begun processing one of them, the contractor shall continue processing that document. The contractor can return the other submission (consistent with the instructions in this chapter) or place it in the provider/supplier file; no further action thereon is required.

(iii) Regardless of whether (2)(i) or (ii) applies, the contractor shall process the submission consistent with the instructions in section 10.6.1.3(B)(1) above.

3. Notice of Voluntary Termination Received from State Agency and/or SOG Location without the Contractor Having Received a Form CMS-855 or Letter Directly From the Provider/Supplier

Although many voluntary termination submissions from certified providers/suppliers are via the Form CMS-855, there are occasions where the provider/supplier will only notify the state agency and/or SOG Location. The contractor will typically learn of this when it receives a Form CMS-1539 (“Medicare/Medicaid Certification and Transmittal”) and/or other written notification from the state/SOG Location. (The state uses the Form CMS-1539 to communicate findings to the SOG Location with respect to a facility’s compliance with health and safety requirements.) In such situations, the following apply:

(i) The contractor may accept from the state/SOG Location written documentation other than the Form CMS-1539. This includes, for example, a Form CMS-2007 or even a voluntary termination letter of the type described in sections 10.6.1.3(B)(1) and (B)(2) above; indeed, the provider/supplier sometimes sends its termination letter directly to the state/SOG Location and the latter simply forwards it to the contractor.

If the contractor has questions concerning said documentation, it shall contact the state/SOG Location for clarification. (This could include situations when it is unclear: (1) whether a termination is involved; (2) which provider/supplier is to be terminated; or (3) if the state forwards to the contractor a termination request that the state received from the provider, whether the state considers it to be a valid termination request.).

(ii) Upon receipt of the Form CMS-1539 (or other/additional state/SOG Location document), the contractor need not develop with the provider/supplier for a Form CMS-855A/B voluntary termination application or a letter. Instead:

(A) The contractor shall abide by the applicable instructions in section 10.6.1.3(C) below (e.g., section (C)(6) regarding effective dates; section (C)(7) concerning cessations of business). If the notice from the state was a voluntary termination letter from the provider/supplier (as described in section 10.6.1.3(B)(3)(i) above), the contractor shall pay particular attention to the instructions in section 10.6.1.3(C)(3) below.

(B) The contractor shall e-mail a copy of the draft approval letter (see section 10.7.20 of this chapter) containing the appropriate termination effective date, reason for termination, and source of the termination notice to MedicareProviderEnrollment@cms.hhs.gov, with “S&C Voluntary Termination” in the subject line.

(C) PEOG will update ASPEN, notify the contractor thereof, and, if the provider/supplier is deemed, provide the contractor the name and e-mail address of the applicable AO.

(D) Within 3 business days of receiving of the aforementioned notice from PEOG, the contractor shall: (1) e-mail a copy of the final signed letter to the provider/supplier, SOG Location, state agency, and AO (if the provider/supplier is deemed); and (2) deactivate the provider/supplier in PECOS pursuant to the instructions/guidance in section 10.6.1.3(C)(9)) below.

4. Notification of Termination Received from the State Agency and/or SOG Location and Directly from the Provider/Supplier Via the Form CMS-855 and/or Letter

The contractor shall adhere to the instructions in this section (B)(4) in the following situations:

- (i) The contractor receives notification of termination (i.e., via Form CMS-1539 or other documentation) from the state/SOG Location after the provider/supplier has been deactivated in PECOS pursuant to the latter's Form CMS-855/letter voluntary termination submission - Within 10 calendar days of receiving the state/SOG Location notification, the contractor shall inform the state/SOG Location via e-mail that the provider/supplier has already been deactivated in PECOS and terminated in ASPEN. No further action by the contractor is necessary.
- (ii) The contractor receives notification of termination from the state/SOG Location while the contractor is processing a Form CMS-855/letter voluntary termination submission but before the provider/supplier has been deactivated in PECOS – The contractor shall: (i) continue processing the application/letter normally and to completion, consistent with the instructions in this section 10.6.1.3; and (ii) e-mail a copy of the final signed letter to the provider/supplier, SOG Location, state agency, and AO (if the provider/supplier is deemed) after the provider/supplier has been deactivated.
- (iii) The contractor receives notification of termination (i.e., via Form CMS-1539 or other documentation) from the state/SOG Location before the contractor received or began processing the provider's/supplier's Form CMS-855/letter voluntary termination submission – The contractor:
 - (A) Shall follow the instructions in section 10.6.1.3(B)(3) above
 - (B) Need not contact the provider/supplier about its Form CMS-855/letter submission prior to the completion of all of the steps in section 10.6.1.3(B)(3)(ii) above
 - (C) Either in the termination approval letter (which the contractor may modify for the purpose) sent to the provider/supplier or via a simultaneous or separate e-mail to the provider/supplier, the contractor shall notify the provider/supplier that its submission to the contractor was not processed due to the provider/supplier's prior notification to the state/SOG Location. (If this communication is sent separately from the approval letter or the e-mail containing the letter, the contractor shall send the separate e-mail no later than 10 calendar days after sending the letter.)

- (iv) *The contractor receives notification of termination from the state/SOG Location and a separate voluntary termination Form CMS-855/letter from the provider/supplier without having begun the processing of either* – The contractor has the discretion to determine which submission to process. It need not process both of them; the submission that the contractor does not process may be returned (consistent with the instructions in this chapter) or placed in the provider/supplier file, and the contractor need take no further action thereon.

C. Additional Certified Provider/Supplier Voluntary Termination Policies

1. *Completion of Form CMS-1539* – The state completes the Form CMS-1539. In Part II thereof, the following fields contain: (i) 26-Termination Action “00”; Code for a voluntary termination; and (ii) 28 –Termination Date; this is the effective date of the voluntary termination.
2. *Required Contents of Voluntary Termination Letter Received Directly from Provider/Supplier* – If the contractor is processing a voluntary termination letter it received directly from the provider/supplier (as opposed to receiving it from the state/SOG Location), the contractor shall ensure that the letter:
 - Is on the provider/supplier’s letterhead
 - Contains the provider/supplier’s legal business name, NPI, and CMS Certification Number (CCN)
 - States with sufficient clarity (in the contractor’s judgment) that the provider/supplier wishes to terminate its Medicare provider/supplier agreement and/or enrollment. (No exact, uniform, standard language from the provider/supplier is necessary; the letter must merely furnish adequate notice of the provider/supplier’s intentions).
 - Is signed and dated by an authorized representative of the provider/supplier. This person need not be on file as an authorized or delegated official of the provider/supplier. The contractor shall accept the person’s signature if it has no reason to suspect that he/she lacks the authority to act on the provider/supplier’s behalf. If it has doubts, however, it may contact its PEOG for guidance.

(The applicable regulations do not require that the letter contain the termination effective date or the reason for the termination. For purposes of ascertaining the effective date and reason, the contractor shall follow the instructions in section 10.1.3(C)(6).)

If the letter does not meet all of the above requirements, the contractor shall develop with the provider/supplier for the missing or deficient information. Development shall be consistent with the general developmental instructions in this chapter (e.g., 30 days for provider/supplier to respond) except as follows:

- *The contractor may develop for the missing or clarifying information via any means, even by telephone. No application development letter is required.*
- *Except as stated in sections 10.6.1.3(C)(3) and (C)(6) below, all missing or clarifying data must be furnished via a new letter signed by an authorized representative (who need not be the same person who signed the original letter).*

If the provider/supplier fails to respond fully and completely to the aforementioned request within the required timeframe, the contractor shall contact its PEOG BFL for guidance and include a copy of the initial provider/supplier letter in the e-mail to PEOG.

(See section 10.6.1.3(C)(3) below for instances where the guidance in this section 10.6.1.3(C)(2) may apply to voluntary termination letters submitted to the state/SOG Location rather than to the contractor.)

3. *Provider/Supplier's Voluntary Termination Letter Received Directly from the state/SOG Location Without the Contractor Having Received a Termination Notification from the Provider/Supplier* – *As explained in section 10.6.1.3(B)(3) above, the contractor may receive a provider/supplier's voluntary termination letter directly from the state/SOG Location without having received any termination notification (i.e., letter or Form CMS-855) from the provider/supplier. If the contractor encounters this situation, the contractor shall adhere to the following:*
 - (i) *Provider/Supplier Voluntary Termination Letter Received from State/SOG Location Without Other Confirming Documentation* - *If the letter is unaccompanied by a Form CMS-1539 or other documentation signifying that the state/SOG Location (1) considers the termination letter as valid or (2) otherwise accepts the termination request, the contractor shall contact the state via e-mail for clarification on these issues. If the state indicates that it considers the provider/supplier as having terminated its provider/supplier agreement, the contractor shall process the termination consistent with the instructions in section 10.6.1.3(B)(3); any missing or unclear information (e.g., reason for the termination, effective date, CCN) shall be obtained from the state and/or SOG Location. If the state is merely forwarding the provider/supplier letter to the contractor for processing without making any determination as to whether the termination is valid, the contractor shall process the letter consistent with the instructions in section 10.6.1.3(B)(1) and (C)(2).*
 - (ii) *Provider/Supplier Voluntary Termination Letter Received from State/SOG Location With Additional Documentation Confirming that the State Considers the Provider/Supplier As Having Terminated Its Agreement* - *The contractor shall process the termination consistent with the instructions in section 10.6.1.3(B)(3).*
4. *Tie-Out Notices* – *SOG Locations no longer issue tie-out notices (Form CMS-2007) for voluntary terminations.*
5. *Special Payments* - *Upon receipt of a Form CMS-855 voluntary termination application or a voluntary termination letter directly from the provider/supplier per the instructions in this section 10.6.1.3, the contractor may (but is not required to) ask the provider/supplier to complete or update the "Special Payments" portion of Section 4 of the Form CMS-855 so that future payments can be sent thereto. If the provider/supplier is adding a special payment address, it should be included in the same transaction as the voluntary termination action (i.e., one transaction incorporating both items). If the provider/supplier is changing its existing special payments address, the transaction constitutes a separate change request (i.e., one termination and one change request). The provider/supplier is not required to submit a Form CMS-588 in conjunction with a termination.*

6. Termination Effective Dates and Termination Reasons – As noted previously, § 489.52(b) outlines the applicable effective dates for voluntary terminations. The contractor shall adhere to the following instructions regarding these dates as well as certain situations pertaining to termination reasons:
- (i) The contractor receives a Form CMS-855 or voluntary termination letter per section 10.6.1.3(B)(1) or (B)(2) (i.e., the contractor receives a termination submission from the provider/supplier before receiving notification from the state/SOG Location):
- (A) If the provider/supplier's submission is missing either the effective date of termination or the reason for the termination (or if either data element is not sufficiently clear to the contractor), the contractor shall develop with the provider/supplier for the missing/unclear data. The contractor may develop for the information via any means, even by telephone; no development letter is required. The provider/supplier must furnish the data via e-mail or other written format, but a new letter is not required. If the provider/supplier fails to submit the requested data within 30 days, the contractor shall contact its PEOG BFL for guidance. If the provider/supplier submits the data, the following effective dates apply:
- (1) The termination reason is that the provider/supplier has ceased business (which includes non-operational status) – The termination effective date in ASPEN is that on which the provider/supplier stopped providing services to the community. (See section 10.6.1.3(C)(6)(i)(C) below for additional instructions concerning cessations of business.)
- (2) The termination reason does not involve a cessation of business or non-operational status (e.g., the provider simply wishes to depart Medicare without closing its business; the provider elects not to renew its state license) – The contractor shall include on the draft approval letter the termination effective date the provider/supplier furnished. However, the contractor shall include in its e-mail to PEOG (see section 10.6.1.3(B)(1)(ii) above) notification as to whether this effective date is less than 6 months from the date on which the contractor first received the provider/supplier's Form CMS-855/letter. If it is less than 6 months, PEOG will determine whether this termination effective date is acceptable.
- (B) If the provider/supplier's initial submission contains the termination effective date and reason, and no development on these issues is needed, the contractor shall proceed as instructed per, as applicable, sections 10.6.1.3(B)(1), (B)(2), and (C)(6)(i)(A) above.
- (C) In cases where a cessation of business (including non-operational status) is involved, a retroactive termination effective date is permissible if there were no Medicare beneficiaries receiving services from the facility on or after the requested termination date. As stated in section 10.4(I) of chapter 10, the contractor shall confirm this via a claims review prior to forwarding the e-mail and approval letter to PEOG per section 10.6.1.3(B)(1)(ii). If claims were submitted, the contractor shall contact the provider/supplier via e-mail to confirm that services were indeed rendered and adjust the termination date with the provider/supplier; if no adjustment is made or contact cannot be made, an overpayment request must be issued.

(ii) The contractor is processing a Form CMS-1539 or other documentation received from the state/SOG Location other than the provider/supplier's voluntary termination letter – The contractor shall use the termination date listed on the Form CMS-1539 or other documentation as the termination effective date, even if a subsequent submission from the provider/supplier (e.g., Form CMS-855) uses a different date. If no termination date is listed on the submission from the state/SOG Location, the contractor shall contact the state agency for guidance.

Except as otherwise stated in this section 10.6.1.3 or unless directed otherwise by PEOG, the contractor: (1) shall use/apply the termination effective date listed on whichever submission it is processing (e.g., the contractor is processing the provider's Form CMS-855 voluntary termination application before receiving any documentation from the state); and (2) need not alter this termination effective date based on a subsequent submission from provider/supplier or the state/SOG Location.

7. State Agency Performs Survey Based on Cessation of Business

(i) Solicitation of Information

As discussed in section 10.4(I)(3)(c) of this chapter, situations may arise where the state (i) performs a survey of a certified provider/supplier based on a compliant or a cessation of business and (ii) finds that the provider/supplier is no longer operational and/or has vacated the practice location. The state will notify the contractor of its findings via the Form CMS-1539 or other documentation. Upon receipt of this documentation, the contractor shall send to the provider/supplier the applicable notice in section 10.7.2 of this chapter requesting that the provider/supplier: (1) provide evidence to the contractor (with a copy to the state) that it is still operational; (2) submit a request to the contractor (either via letter or a Form CMS-855) to voluntarily terminate its enrollment; or (3) submit a Form CMS-855 change of information application to report a changed practice location address (and any other changed data). The contractor shall copy the state and SOG Location on the notice and give the provider/supplier 10 calendar days from the date the notice is sent to respond to the request.

(ii) Potential Outcomes

(A) The provider/supplier timely furnishes evidence to the contractor and the state that it is still operational at the same location – The contractor need take no additional action on the matter until it receives confirmation from the state concerning the latter's review. (If the contractor receives evidence from the provider/supplier more than 10 days after the request was made, it shall contact the state for guidance.)

While the contractor may forward the provider/supplier's evidence to the state to ensure that the latter received it, the contractor is not required to do so. It is ultimately (1) the provider/supplier's responsibility to copy the state on its submission to the contractor and (2) up to the state to determine whether the evidence of operational status the provider/supplier submitted is sufficient.

Upon receiving notice from the state as to the review's results, the contractor shall follow the applicable instructions in this section 10.6.1.3 if the provider/supplier is to be terminated (e.g., the state sends a Form CMS-1539 to the contractor). If the provider/supplier was indeed found operational, the contractor need take no further action.

(B) The provider/supplier submits a Form CMS-855 voluntary termination and/or a voluntary termination letter in response to the contractor's aforementioned solicitation - The contractor shall process the submission consistent with the instructions in section 10.6.1.3(B)(1) and/or (B)(2), as applicable. Notwithstanding any instruction to the contrary in this section 10.6.1.3, the contractor shall use the termination effective date listed on the Form CMS-1539 or other documentation from the state (rather than the date on the Form CMS-855/letter) as the termination effective date.

(C) The provider/supplier timely submits a Form CMS-855 to change its address – The contractor shall process the change request to completion, notify the provider/supplier thereof via the applicable instructions in this chapter 10, and forward a copy of the change request via e-mail to the state and SOG Location via e-mail. In this e-mail, the contractor shall: (1) notify the state/SOG Location of the new address; (2) reference the Form CMS-1539 (or other documentation) that the state had sent to the contractor; and (3) notify the state if PECOS indicated any addresses other than the “old” or “new” address at which the provider/supplier might be located.

(D) The provider/supplier fails to respond to the contractor's solicitation - The contractor shall process the voluntary termination consistent with the instructions in section 10.6.1.3(B)(3) above.

8. Clock Stoppages – In any circumstance where the contractor is required under section 10.6.1.3 to contact PEOG (including sending a termination to PEOG for approval) or the state/SOG Location for a determination, approval, or guidance of some type, the application processing time clock is stopped. It resumes on the date on which the contractor receives PEOG/state/SOG Location's decision, resolution, determination, or final guidance, as applicable. Interim communication between the contractor and PEOG/state/SOG Location during such “waiting periods” (e.g., PEOG request for additional information from the contractor) does not restart the clock. Optional communications---that is, communications with PEOG/state/SOG Location that are not specifically directed under this section 10.6.1.3---do not stop the processing clock.

9. Deactivation Date – As indicated previously, the termination effective date will be entered into ASPEN. The date of deactivation (and except if PEOG instructs otherwise) should match the termination effective date unless the provider is already deactivated in PECOS, in which case no change in the deactivation effective date is needed.

10.6.2 – Establishing Effective Dates

(Rev. 10524; Issued: 12-17-20; Effective: 11-13-20; Implementation: 11-13-20)

A. Enrollment Date

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

enrollment is June 1, not January 1. (**NOTE:** The matter of the date of enrollment is separate from the question of the date from which the supplier may bill.)

1. Establishing Effective Dates for Specific Providers/Suppliers

This section applies to the following individuals and organizations: physicians; physician assistants; nurse practitioners; audiologists; clinical nurse specialists; certified registered nurse anesthetists; anesthesiology assistants; certified nurse- midwives; clinical social workers; clinical psychologists; independently billing psychologists, registered dietitians or nutrition professionals; physical therapists; occupational therapists; speech-language pathologists; physician and non-physician practitioner organizations (e.g., group practices) consisting of any of the categories of individuals identified above; and ambulance suppliers and opioid treatment programs.

2. Background

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

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

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

3. Retrospective Billing

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

- The supplier has met all program requirements, including state licensure requirements, and
- The services were provided at the enrolled practice location for up to—
- 30 days prior to their effective date if circumstances precluded enrollment in advance of providing services to Medicare beneficiaries, or
- 90 days prior to their effective date if a Presidentially-declared disaster under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. §§5121-5206 (Stafford Act) precluded enrollment in advance of providing services to Medicare beneficiaries.

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

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

4. Legal Distinction Between Effective Date of Enrollment and Retrospective Billing Date

The effective date of enrollment is “the later of the date of filing or the date (the supplier) first began furnishing services at a new practice location.” The retrospective billing date, however, is “up to...30 days prior to (the supplier’s) effective date (of enrollment).” To illustrate, suppose that a non-Medicare enrolled physician begins furnishing services at an office on March 1. She submits a Form CMS-855I initial enrollment application on May 1. The application is approved on June 1. The physician’s effective date of enrollment is May 1, which is the later of: (1) the date of filing, and (2) the date she began furnishing services. The retrospective billing date is April 1 (or 30 days prior to the effective date of enrollment), assuming that the requirements of 42 CFR §424.521(a) are met.

NOTE: However, that the effective date entered into the Provider Enrollment, Chain and Ownership System (PECOS) and the Multi-Carrier System will be April 1 and that claims submitted for services provided before April 1 will not be paid.

B. Effective Date For Reassignment

If the Form CMS-855R is accompanied by an initial Form CMS-855I or submitted as a “stand-alone” form (that is, a Form CMS-855R is submitted as a new reassignment, such as when an enrolled physician who is operating as a sole proprietor joins a group practice and reassigns his benefits to the group), the effective date of the enrollment and the reassignment shall be consistent with the retrospective billing rule (i.e., the later of the date of filing or the date the reassigning provider or supplier first began furnishing services at the new location) specified in section 10.6.2(A)(3)) of this chapter.

C. Effective Date for Certified Providers and Certified Suppliers

The final Fiscal Year (FY) 2011 Hospital Inpatient Prospective Payment System (IPPS) final rule was published on August 16, 2010 (75 FR 50042) and became effective October 1, 2010. Several provisions in the rule directly affect areas of survey and certification responsibility.

Section 489.13 governs the determination of the effective date of a Medicare provider agreement or supplier approval for health care facilities that are subject to survey and certification. Section 489.13 was revised to clarify that the date of a Medicare provider agreement or supplier approval may not be earlier than the latest date on which all applicable federal requirements have been met. Such requirements include the Medicare contractor’s review and verification of the provider/supplier’s Form CMS-855 application.

These clarifications were necessary because of a September 28, 2009 decision of the Appellate Division of the Department Appeals Board (DAB). The DAB’s interpretation of §489.13 was that it did not include enrollment application processing as among the Federal requirements that must be met. In that case, a State Agency (SA) had conducted a survey of an applicant on July 6, 2007, prior to receiving the November 21, 2007 notice from the Medicare contractor that was recommending approval of the applicant’s enrollment application. The CMS Regional Office (RO) issued a provider approval effective November 21, 2007, consistent with our traditional interpretation of §489.13. The DAB, however, ruled that the effective date must be July 6, 2007.

The DAB agreed with the applicant that the requirement for the Medicare contractor to verify and determine whether an application should be approved is not a requirement for the provider to meet [under §489.13], but rather a requirement for Medicare contractor action (DAB Decision No. 2271, page 5).

Although SAs and accreditation organizations (AOs) are aware that - in accordance with Section 2003B of the State Operations Manual (SOM) - they should not perform a survey of a new facility until the Medicare contractor has made a recommendation for approval, circumstances do occur where the sequence is reversed. AOs, in particular, often find it challenging to confirm whether the Medicare contractor has made its recommendation. This is because AOs are dependent upon the applicant providing copies of the pertinent notices. When the survey occurs prior to the enrollment verification activities, we believe it is essential that the provider agreement or supplier approval date be based on the later date, i.e., the date on which the contractor determined that the enrollment application verification.

Accordingly, §489.13(b) now states that:

“Federal requirements include, but are not limited to –

- (1) Enrollment requirements established in part 424, Subpart P, of this chapter. CMS determines, based upon its review and verification of the prospective provider’s or supplier’s enrollment application, the date on which enrollment requirements have been met;
- (2) The requirements identified in §§489.10 and 489.12; and
- (3) The applicable Medicare health and safety standards, such as the applicable conditions of participation, the requirements for participation, the conditions for coverage, or the conditions for certification.”

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

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

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

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

E. Effective Date for MDPP Suppliers

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

- The date the supplier filed an enrollment application that was subsequently approved,
- The date the supplier filed a corrective action plan that was subsequently approved by a Medicare contractor, or
- The date the supplier first began furnishing services at a new administrative location that resulted in a new enrollment record or Provider Transaction Access Number.

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

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

F. Future Effective Dates

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

10.6.3 – Legal Business Name

(Rev. 10524; Issued: 12-17-20; Effective: 11-13-20; Implementation: 11-13-20)

A. Legal Business Name –Punctuation and Special Characters

PECOS and NPPES allow for the entry of punctuation and certain special characters in the provider's Legal Business Name (LBN). Examples of acceptable punctuation and special characters are ampersands, apostrophes, commas, hyphens, left and right parentheses, periods, pound signs, and quotation marks.

When punctuation or special characters are part of a provider's LBN as shown on the IRS CP-575, the punctuation or special characters should also appear in the LBN in NPPES and the LBN in PECOS. However, the contractor may use its discretion with respect to accepting a match between NPPES and PECOS if a comma or a period is the only discrepancy between the LBN in NPPES and the LBN in PECOS. The contractor should not delay processing a provider's Medicare enrollment application by requiring the provider to change its LBN in NPPES in order to conform to a discrepancy related to punctuation and/or special character.

Examples of LBN Matches and Non-Matches and Actions to Be Taken

| NPPES LBN | PECOS LBN | Exact Match |
|-------------------------------|---------------------------------|---|
| Health Systems, Inc. | HEALTH SYSTEMS, INC. | Yes, this is an exact match. |
| Quality Care, Incorporated | Quality Care, Inc. | No, this is not an exact match (because of the abbreviation ‘Inc.’ in the PECOS LBN). In this case, the contractor may accept the match since both versions are an accurate match (e.g., Incorporated or Inc; Limited Liability Company or LLC; etc.) |
| Health & Rehabilitation, Inc. | Health and Rehabilitation Inc. | No, this is not an exact match (because the ampersand and ‘and’ do not match). In this case, the contractor shall refer to the IRS CP-575. If the ampersand is displayed on the IRS CP-575, the Medicare contractor may accept the match. If the ampersand is not present and the word ‘and’ is present, the Medicare contractor shall ask the provider to correct its NPPES information. The provider must change its LBN in NPPES to read in accordance with the IRS CP-575. |
| Allergy & Asthma, Inc. | Allergy & Asthma, INC. | Yes, this is an exact match. Upper and lower cases do not affect a match. |
| Foot-Ankle, LLC | Foot Ankle LLC | No, this is not an exact match (because the hyphen is in one LBN but not in the other). In this case, the contractor shall refer to the IRS CP-575. If the hyphen is displayed on the IRS CP-575, the contractor may accept the match. If the hyphen is not present, the contractor shall ask the provider to correct its NPPES information. The provider must change its LBN in NPPES to read in accordance with the IRS CP-575. |
| Rehab and Health, Inc. | Rehabilitation and Health, Inc. | No, this is not an exact match (because ‘Rehab’ and ‘Rehabilitation are different words). In this case, the contractor should refer to the IRS CP-575. If the LBN ‘Rehab and Health, Inc.’ is displayed on the IRS CP-575, the contractor may accept the match. If ‘Rehabilitation and Health, Inc.’ is present, the contractor should ask the provider to correct its NPPES information. The provider must change its LBN in NPPES to read in accordance with the IRS CP-575. |

Many enrolled providers may actually be subparts of other enrolled providers, and some of those subparts entered their “doing business as name” as their LBN when applying for their NPIs. Once a contractor determines for certain that this situation exists, the contractor shall ask the provider to correct its NPPES information. The provider can (1) change its LBN in NPPES to

read in accordance with the IRS CP-575, and (2) report its “doing business as” name in NPPES as an “Other Name” and indicate the type of other name as a “doing business as” name.

10.6.4 – Provider and Supplier Business Structures

(Rev. 10524; Issued: 12-17-20; Effective: 11-13-20; Implementation: 11-13-20)

This section explains the legalities of various types of business organizations that may enroll, including sole proprietorships. Note that the provider’s organizational structure can have a significant impact on the type of information it must furnish on the Form CMS-855 or CMS-20134.

Business organizations are generally governed by State law. Thus, State X may have slightly different rules than State Y regarding certain entities. (In fact, X may permit the creation of certain types of legal entities that Y does not.) The discussion below gives only a broad overview of the principal types of business entities and does not take into account different State nuances.

Since CMS issues a 1099 based on an enrolled entity’s business structure, providers and suppliers should consult with their accountant or legal advisor to ensure that they are establishing the correct business structure.

A. Sole Proprietorships

A business is a sole proprietorship if it meets all of the following criteria:

- It files a Schedule C (1040) with the IRS (this form reports the business’s profits/losses);
- One person owns all of the business’s assets; and
- It is not incorporated.

A sole proprietorship is not a corporation. Suppose a physician operates his/her business as a home health agency. If he/she incorporates his/her business, the business becomes a corporation (even though the physician is the only stockholder). Thus, the frequently used term “unincorporated sole proprietorship” is a misnomer because sole proprietorships by definition are unincorporated. In addition, merely because the sole proprietor hires employees does not mean that the business is no longer a sole proprietorship. Assume that W is a sole proprietor and he hires X, Y, and Z as employees. W’s business is still a sole proprietorship because he remains the 100% owner of the business. If, however, W had sold parts of his sole proprietorship to X, Y, and Z, the business would no longer be a sole proprietorship, as there is now more than one owner.

Note that professional associations (PAs) are generally not considered to be sole proprietorships; the PA designation is typically used in States that do not allow individuals to incorporate and form professional corporations. The PA will have its own Employer Identification Number and is considered, like a professional corporation, to be a legal entity that is separate and distinct from the individual.

B. Processing Enrollment for Sole Proprietorships

If the provider indicates in the Identifying Information/Business Information section of the Form CMS-855A, CMS-855B, CMS-855I, CMS-855S or CMS-20134 that he/she is a sole proprietor, the contractor shall note the following:

- The LBN in the Business Information section should list the person's (the sole proprietor's) legal name.
- The TIN in the Business Information section should list the person's social security number.
- The Final Adverse Legal Actions/Convictions section of the Form CMS-855A, CMS-855B, CMS-855I, CMS-855S or CMS-20134 must be completed with information about the individual's final adverse action history.
- The Organizational Ownership and/or Managing Control section of the Form CMS-855A, CMS-855B, CMS-855I, CMS-855S or CMS-20134 will not apply unless the person has hired an entity to exercise managerial control over the business (i.e., no owners will be listed in the section, as the sole owner has already reported his/her personal information in the Identifying Information and Adverse Legal Actions sections).
- No owners, partners, or directors/officers need to be reported in the Individual Ownership and/or Managing Control section. However, all managing employees (whether W-2 or not) must be listed.
- The sole proprietor may list multiple authorized or delegated officials in the Certification Statement and Delegated Official sections.

Since most sole proprietorships that complete the Form CMS-855A, CMS-855B, CMS-855I, CMS-855S or CMS-20134 will also have an employer identification number (EIN), the contractor shall request from the provider a copy of its CP-575, any federal tax department tickets, or any other preprinted information from the IRS containing the provider's EIN.

1. 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 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.

C. Partnerships

A partnership is an association of two or more persons/entities who carry on a business for profit. Each partner in a partnership is an owner. If A and B form the "Y Partnership" and each contributes \$50,000 to start up the business, each partner owns one-half of Y.

In several respects, a partnership is the opposite of a corporation:

- Each partner is liable for all the debts of the partnership. Using the example above, suppose the Y Partnership breached a contract it had with X, who now sues for \$10,000. Since each partner is liable for all debts, X can collect the entire \$10,000 from A, or from B, or \$5,000

from each, etc. This is because, unlike a corporation, a partnership is not really a separate and distinct entity from its partners/owners; the partners are the partnership. If Y had been a corporation, the owners (A and B) would likely have been shielded from liability.

- There is no “double taxation” with partnerships. The partnership itself does not pay taxes, although each partner pays taxes on any income he/she earns from the business.
- Unlike a corporation, a partnership generally does not file papers with the State upon its creation (i.e., it does not file the equivalent of articles of incorporation). Instead, a partnership has a “partnership agreement,” which amounts to a contract between the partners outlining duties, responsibilities, powers, etc.
- Each partner has the right to participate in running the business’s day-to-day operations, unless the partnership agreement dictates otherwise.

An alternative type of partnership is a limited partnership (as opposed to a “general partnership,” described above). While possessing many of the characteristics of a general partnership, there are some key differences. First, a limited partnership (LP) must file formal documents with the State. Second, a LP has two types of partners –general and limited. The general partner(s) runs the business, yet is personally responsible for all of the LP’s debts. Conversely, the limited partner(s) has limited liability yet cannot participate in the management of the business.

D. Limited Liability Companies (LLC)

A limited liability company (LLC) is a legal entity that is neither a partnership nor a corporation, but has characteristics of both. Its owners have limited liability (just like stockholders in a corporation). Also, the LLC does not pay Federal taxes (similar to a partnership), although its owners – usually referred to as “members” - must pay taxes on any dividends they earn. An LLC thus contains the best attributes of corporations and partnerships; LLCs are therefore rapidly gaining in popularity.

An LLC should not be confused with a limited liability corporation, which is a type of corporation in some States. A limited liability company is not a corporation or partnership, but a distinct legal entity created and regulated by special State statutes.

Note that certain Form CMS-855 or CMS-20134 information is required of different entities. The primary example of this is in the Individual Ownership and/or Managing Control section. If the provider is a corporation, it must list its officers and directors on the form. Partnerships and LLCs, on the other hand, do not have officers or directors and thus need not list them.

E. Joint Ventures

A joint venture is when two or more persons/entities combine efforts in a business enterprise and agree to share profits and losses. It is very similar to a partnership, and is treated as a partnership for tax purposes. The key difference is that a partnership is an ongoing business, while a joint venture is a temporary, one-time business undertaking. A joint venture, therefore, can be classified as a “temporary partnership.”

F. Corporations

A corporation is an entity that is separate and distinct from its owners (called stockholders, or shareholders). To form a corporation, various documents – such as articles of incorporation – must be filed with the State in which the business will incorporate. The key elements of a corporation are:

- **Limited Liability** – This is the main reason for a business’s decision to operate as a corporation. Suppose Corporation X has ten stockholders, each owning 10% of the business. X breached a contract it had with Company Y, which now wants to sue X’s owners. Unfortunately for Y, it can generally only sue X itself; it cannot sue X’s shareholders. The corporation’s owners are essentially shielded from liability for the actions of the corporation because, as stated above, a corporation is separate and distinct from its owners.

Despite the concept of limited liability, there may be instances where a corporation’s owners/stockholders can be held personally liable for the corporation’s debts. This is known as “piercing the corporate veil,” whereby one tries to get past the brick wall of the corporation in order to collect from the owners behind that wall. However, piercing the corporate veil is a difficult thing to do and many courts are unwilling to allow it, meaning that plaintiffs can only collect from the corporation itself.

- **“Double” Taxation** – This is the principal reason for a business’s decision not to be a corporation. “Double” taxation means that: (1) the corporation itself must pay taxes, AND (2) each shareholder must pay taxes on any dividends he/she receives from the business.
- **Board of Directors** – Most corporations are run by a governing body, typically called a Board of Directors.

Two special types of corporations that contractors may encounter are:

- **“Professional Corporation” or “PC.”** In general, a PC (1) is organized for the sole purpose of rendering professional services (such as medical or legal), and (2) all stockholders in a PC must be licensed to render such services. Thus, if A, B and C want to form a physician practice (each is a 1/3 stockholder) and only A is a medical professional, a PC probably cannot be formed (depending, of course, on what the applicable State PC statute says). In addition, the title of a PC will usually end in “PC,” “PA” (Professional Association) or “Chartered.”
- **“Close” Corporation (or “closely-held” corporation)** – This is a type of corporation with a very limited number of stockholders. Unlike a “regular” corporation, the entity’s board of directors generally does not run the business; rather, the shareholders do. The stock is typically not sold to outsiders.

Although PCs and close corporations (CCs) are considered “corporations” for enrollment purposes, State laws governing these entities are often different from those that govern “regular” corporations (i.e., States have separate statutes for “regular” corporations and for PCs/CCs.) In many cases, an entity must specifically elect to be a PC or CC when filing its paperwork with the State.

G. Non-Profit Organizations

The term “non-profit organization” (NPO) is misleading. It does not signify an organization that is forbidden to make a profit. Rather, it means that all of the organization’s profits are put back

into the entity to promote its goals, which are usually political, social, religious, or charitable in nature. In other words, an NPO is not organized primarily for profit, but instead to further some other goal. An entity can acquire NPO status by obtaining a 501(c)(3) certification from the IRS (meaning it is tax-exempt) or by acquiring such status from the State in which it is located.

The NPO status is important for enrollment purposes because NPOs generally do not have owners. Thus, a NPO need not list any owners in sections 5 or 6 of the Form CMS-855 or CMS-20134.

H. Government-Owned Entities

For purposes of enrollment, a government-owned entity (GOE) exists when a particular government body (e.g., Federal, State, city or county agency) will be legally and financially responsible for Medicare payments received. For example, suppose Smith County operates Hospital X. Medicare overpaid X \$100,000 last year. If Smith County is the party responsible for reimbursing Medicare this amount, X is considered a government-owned entity.

Note that:

- GOEs do not have “owners.” Thus, the Organizational Ownership and/or Managing Control sections of the Form CMS-855 or CMS-20134 need only contain the name of the government body in question. Using our example above, this would be Smith County.
- For the Individual Ownership and/or Managing Control section of the Form CMS-855 or CMS-20134, the only people that must be listed are “managing employees.” This is because GOEs do not have corporate officers or directors.

The provider must submit a letter from the government body certifying that the government entity will be responsible for any Medicare payments.

10.6.5 – National Provider Identifier (NPI)

(Rev. 10524; Issued: 12-17-20; Effective: 11-13-20; Implementation: 11-13-20)

A. Submission of NPI

Every provider or supplier that submits an enrollment application must furnish its NPI(s) in the applicable section(s) of the Form CMS-855 or CMS-20134. The provider need not submit a copy of the NPI notification it received from the National Plan and Provider Enumeration System (NPPES) unless the contractor requests it to do so. Similarly, if the provider obtained its NPI via the Electronic File Interchange (EFI) mechanism, the provider need not submit a copy of the notification it received from its EFI Organization (EFIO) unless the contractor requests it to do so. (The notification from the EFIO will be in the form of a letter or e-mail.) If the contractor requests paper documentation of a provider’s NPI, the contractor may accept a copy of the provider’s NPI Registry’s Details Page in lieu of a copy of the NPI notification. The Details Page contains more information than is contained on the NPI notification, and providers may be able to furnish NPI Registry Details Pages more quickly than copies of their NPI notifications.

The aforementioned requirement to list all applicable NPIs on the Form CMS-855 or CMS-20134 applies to all applications. (The only exceptions to this involve voluntary terminations, deactivations, deceased providers, and change of ownership (CHOW) applications submitted by the old owner. NPIs are not required in these instances.) Thus, for instance, if a reassignment

package is submitted, the NPIs for all involved individuals and entities must be furnished; even if an individual is reassigning benefits to an enrolled group, the group's NPI must be furnished on the Form CMS-855R.

NOTE: The National Supplier Clearinghouse (NSC) shall obtain the NPPES notification from the applicant or verify the NPI and the Type of NPI (i.e., Type 1 or Type 2) through the NPI Registry.

B. Additional NPI Information

If a provider submits an NPI notice to the contractor as a stand-alone document (i.e., no Form CMS-855 or CMS-20134 was submitted), the contractor shall not create a logging & tracking (L & T) record in PECOS for the purpose of entering the NPI. The contractor shall simply place the notice in the provider file. The contractor shall only enter NPI data into PECOS that is submitted in conjunction with a Form CMS-855 or CMS-20134 (e.g., initial, change request). Thus, if a provider submits a Form CMS-855 or CMS-20134 change of information that only reports the provider's newly assigned NPI, or reports multiple NPIs that need to be associated with a single Medicare identification number, the contractor may treat this as a change request and enter the data into PECOS.

C. Subparts - General

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

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

D. Medicare Subparts Paper - Text

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

Purpose of this Paper

Medicare assigns unique identification numbers to its enrolled health care providers. They are used to identify the enrolled health care providers in the HIPAA standard transactions that they conduct with Medicare (such as electronic claims, remittance advices, eligibility inquiries/responses, claim status inquiries/responses, and coordination of benefits) and in cost reports and other non-standard transactions.

This paper is a reference for Medicare contractors. It reflects the Medicare program's expectations on how its enrolled organization health care providers that are covered entities

under HIPAA¹ will determine subparts and obtain NPIs for themselves and any subparts. These expectations may change over time to correspond with any changes in Medicare statutes, regulations, or policies that affect Medicare provider enrollment.

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

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

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

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

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

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

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

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

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

- A subpart is not itself a separate legal entity, but is a part of a covered organization health care provider that is a legal entity. (All covered entities under HIPAA are legal entities.)
- A subpart furnishes health care as defined at 45 CFR § 160.103.

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

- A subpart may or may not be located at the same location as the covered organization health care provider of which it is a part.
- A subpart may or may not have a Taxonomy (Medicare specialty) that is the same as the covered organization health care provider of which it is a part.
- Federal statutes or regulations pertaining to requirements for the unique identification of enrolled Medicare providers may relate to entities that could be considered subparts according to the discussion in the NPI Final Rule. Medicare covered organization health care providers must take any such statutes or regulations into account to ensure that, if Medicare providers are uniquely identified now by using Medicare identifiers in HIPAA standard transactions, they obtain NPIs in order to ensure they can continue to be uniquely identified. Medicare is transitioning from the provider identifiers it currently uses in HIPAA standard transactions (for organizations, these could be CCNs, Provider Transaction Access Numbers (PTANs), or NSC Numbers—known as legacy identifiers or legacy numbers) to NPIs. This makes it necessary that Medicare organization health care providers obtain NPIs because the NPIs have replaced the identifiers currently in use in standard transactions with Medicare and with all other health plans. In addition, Medicare organization health care providers must determine if they have subparts that need to be uniquely identified for Medicare purposes (for example, in HIPAA standard transactions conducted with Medicare). If that is the case, the subparts will need to have their own unique NPIs so that they can continue to be uniquely identified in those transactions.
- A subpart that conducts any of the HIPAA standard transactions separately from the covered organization health care provider of which it is a part must have its own unique NPI.

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

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

Medicare Organization Providers and Subparts: Certified Providers and Certified Suppliers

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

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

- Providers apply for Medicare enrollment by completing a Form CMS-855A.
- Most providers are surveyed and certified by the States³ prior to being approved as Medicare providers.
- Providers have in effect an agreement to participate in Medicare.⁴
- Providers include, but are not limited to: skilled nursing facilities, hospitals⁵, critical access hospitals, home health agencies, rehabilitation agencies (outpatient physical therapy, speech therapy), comprehensive outpatient rehabilitation facilities, hospices, community mental health centers, religious non-medical health care institutions.
- Providers are assigned CCNs to identify themselves in Medicare claims and other transactions, including cost reports for those providers that are required to file Medicare cost reports.
- In general, each entity that is surveyed and certified by a State is separately enrolled in Medicare and is considered a Medicare provider. (One exception involves home health agency branches. The branches are not separately enrolled Medicare providers.) In many cases, the enrolled provider is not itself a separate legal entity; i.e., it is an entity that is a part of an enrolled provider that is a legal entity and is, for purposes of the NPI Final Rule, considered to be a subpart.

10 Religious non-medical health care institutions are handled differently.

11 Community mental health centers attest to such an agreement. Religious non-medical health care institutions are handled differently

5 Hospitals bill Medicare Part B for certain types of services 6 The check-digit algorithm will determine the validity of an NPI. This is not the same as knowing the health care provider being identified by a particular NPI.15 There may be exceptions for emergency or very unusual situations.

Certified Suppliers, which bill Medicare Part B:

- Certified suppliers apply for Medicare enrollment by completing a Form CMS-855A or CMS-855B, depending on the supplier type.
- Certified suppliers include ambulatory surgical centers, portable x-ray suppliers, independent clinical labs (CLIA labs), rural health centers, and federally qualified health centers.
- Certified suppliers are typically surveyed and certified by the States prior to being approved for enrollment as Medicare certified suppliers. (For CLIA labs, each practice location at which lab tests are performed must obtain a separate CLIA Certificate for that location, though there are a few exceptions to this.)
- Certified suppliers may have in effect an agreement to participate in Medicare.
- Certified suppliers are assigned CCNs for purposes of identification within Medicare processes. However, the contractors assign unique identification numbers to certain certified suppliers for billing purposes. (For CLIA labs, a CLIA number is typically assigned to each practice location for which a CLIA certificate is issued. A CLIA number may not be used to identify a clinical laboratory as a “health care provider” in HIPAA standard transactions. The CLIA number has no relation to the Medicare PTAN.)
- In many cases, the enrolled certified supplier is not itself a separate legal entity; i.e., it is an entity that is a part of an enrolled provider or certified supplier that is a legal entity and is, for purposes of the NPI Final Rule, considered to be a subpart.

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

Medicare Expectations for NPI Assignments for Providers and Certified Suppliers:

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

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

Medicare, a total of 11 unique NPIs should be obtained: one for the hospital, and one for each of the 10 home health agencies.

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

Medicare Organization Providers and Subparts: Supplier Groups and Supplier Organizations

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

- Supplier groups and supplier organizations apply for Medicare enrollment by completing a Form CMS-855B or CMS-20134.
- Supplier groups and supplier organizations bill Medicare Part B.
- Certain supplier organizations are certified by the States, certified by the Food and Drug Administration (FDA), or must undergo an on-site inspection by the contractor. These requirements vary by type of supplier organization.
- Supplier groups are primarily group practices, such as a group of physicians or other practitioners.
- Supplier organizations include ambulance companies, mammography facilities, independent diagnostic testing facilities (IDTFs) and MDPP Suppliers.

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

1. When there is more than one Medicare specialty code associated with a single TIN. For instance, if a physician group practice is also an IDTF, it has two different Medicare specialties. The supplier group (the physician group practice) must enroll as a group and the supplier organization (the IDTF) must enroll as a supplier organization. The group practice would complete a Form CMS-855B and the IDTF would complete a Form CMS-855B. Each one would receive its own unique Medicare identification number.
2. If a separate site visit, State certification, or on-site inspection by the contractor or if FDA certification is required for each practice location of that supplier group/supplier organization.

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

Medicare Expectations for NPI Assignments for Supplier Groups and Supplier Organizations: To help ensure that Medicare supplier groups and supplier organizations do not

experience delays in Medicare claims processing or reimbursement, Medicare encourages each of its enrolled supplier groups and supplier organizations to obtain its own unique NPI. These NPIs have replaced the legacy numbers that are used today in HIPAA standard transactions and in other transactions, such as cost reports. In order for subpart determinations to mirror Medicare enrollment, each enrolled supplier group and supplier organization that is a covered organization health care provider should ensure the following:

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

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

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

Medicare Organization Providers and Subparts:

DMEPOS Suppliers

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

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

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

Final Notes About NPIs

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

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

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

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

Medicare uses NPIs to identify health care providers and subparts in HIPAA standard transactions. (NPI Final Rule, page 3469: section 162.412(a): “A health plan must use the NPI of any health care provider (or subpart(s), if applicable) that has been assigned an NPI to identify that health care provider on all standard transactions where that health care provider’s identifier is required.”) Medicare ensures that the NPIs it receives in HIPAA standard transactions are valid⁶. Medicare rejects HIPAA standard transactions that contain invalid NPIs. Valid NPIs, however, like the provider identifiers used today, must be “known” to Medicare. Medicare is not permitted to make payments for services rendered by non-Medicare providers⁷, nor is it permitted to reimburse providers that are not enrolled in the Medicare program. Medicare returns, with appropriate messages, any HIPAA standard transactions containing valid but unrecognizable NPIs.

6 The check-digit algorithm will determine the validity of an NPI. This is not the same as knowing the health care provider being identified by a particular NPI.¹⁵ There may be exceptions for emergency or very unusual situations.

15 There may be exceptions for emergency or very unusual situations.

10.6.6 – Final Adverse Actions

(Rev. 10524; Issued: 12-17-20; Effective: 11-13-20; Implementation: 11-13-20)

Unless stated otherwise, the instructions in this section 10.6.6 apply to the following sections of the Form CMS-855 and CMS-20134:

- Final Adverse Actions/Convictions (Section 3 of the CMS-855A, CMS-855B, CMS-855I, CMS-855O and CMS-20134 and Section 7 of the CMS-855S)
- Business Information section/ Private Practice Business Information section of the CMS-855I
- Organizational Ownership and/or Managing Control Final Adverse Legal Action History Section (Section 5 of the of the CMS-855A, CMS-855B, CMS-855I, CMS-855O and CMS-20134 and Section 8 of the CMS-855S)
- Individual Ownership and/or Managing Control Final Adverse Legal Action History Section (Section 6 of the of the CMS-855A, CMS-855B, CMS-855I, CMS-855O and CMS-20134 and Section 9 of the CMS-855S)

A. Prior Approval

If a current exclusion or debarment is disclosed on the Form CMS-855 or CMS-20134, the contractor shall deny the application in accordance with the instructions found in Section 10.6.6(F) of this chapter.

B. Review of PECOS

If the contractor denies an application or revokes a provider based on a final adverse action, the contractor shall search PECOS to determine whether the person/entity with the final adverse action has any other associations, as it applies (e.g., is listed in PECOS as an owner of three Medicare-enrolled providers).

If such an association is found and there are grounds for revoking the billing privileges of the other provider(s), the contractor shall initiate revocation action against the associate provider(s).

C. Chain Home Offices, Billing Agencies, and HHA Nursing Registries

If the contractor discovers that an entity listed in section 7, 8, or 12 of the Form CMS-855A has had a final adverse action imposed against it, the contractor shall contact its PEOG BFL for guidance. For any final adverse actions against individuals listed in section 7 of the Form CMS-20134, contractors shall refer to 10.3.2(A)(1)(f) of this chapter, where this process is outlined in detail.

D. System for Award Management (SAM)

When an entity or individual is listed as debarred in the SAM (formerly, the General Services Administration Excluded Parties List System), the SAM record may identify associated entities and persons that are also debarred. To illustrate, suppose John Smith is identified as debarred. The SAM record may also list individuals and entities associated with John Smith

that are debarred as well, such as “John Smith Company,” “Smith Consulting,” “Jane Smith,” and “Joe Smith.”

If the contractor learns via the Form CMS-855 or CMS-20134 verification process, a Unified Program Integrity Contractor (UPIC) referral, or other similar means that a particular person or entity is debarred, the contractor shall search the person/entity in the SAM to see if the SAM record discloses any associated parties that are debarred. If associated parties are listed, the contractor – after verifying, via the instructions in this chapter, that the associated party is indeed debarred – shall check PECOS to determine whether the party is listed in any capacity. If the party is listed, the contractor shall take all applicable steps outlined in this chapter with respect to revocation proceedings against the party and against any persons/entities with whom the party is associated. For instance, using our example above, if the contractor confirms that Jane Smith is debarred and PECOS shows Jane Smith as an owner of Entity X, the contractor shall, as applicable, initiate revocation proceedings against X.

E. Disclosure of Final Adverse Action

If a final adverse action is disclosed on the Form CMS-855 or Form CMS-20134, the provider must furnish documentation concerning the type of final adverse action being reported, the date of the final adverse action occurred, and what court or governing/administrative body imposed the action. The documentation must be furnished regardless of whether the final adverse action occurred in a state different from that in which the provider seeks enrollment or is enrolled.

In addition:

1. Reinstatements - If the person or entity in question was excluded or debarred but has since been reinstated, the contractor shall confirm the reinstatement through the OIG or, in the case of debarment, through the federal agency that took the action. The contractor shall also ensure that the provider submits written proof of the reinstatement (e.g., reinstatement letter).
2. Scope of Disclosure – All final adverse actions that occurred under the LBN and TIN of the disclosing entity (e.g., applicant; section 5 owner) must be reported.

Example (a) - Smith Pharmacy, Inc. had 22 separately enrolled locations in 2009. Each location was under Smith’s LBN and TIN. In 2010, two locations were excluded by the OIG and then subsequently revoked by CMS, Smith submits a Form CMS-855S application for a new location on Jones Street. Suppose, however, that each of Smith’s locations had its own LBN and TIN. The Jones Street application need not disclose the two revocations from 2010.

Example (b) - An HHA, hospice, and hospital are enrolling under Corporation X’s LBN and TIN. X is listed as the provider in section 2 of each applicant’s Form CMS- 855A. All three successfully enroll. Six months later, Company X’s billing privileges for the HHA are revoked due to an OIG exclusion. Both the hospice and the hospital must report that X was excluded on a Form CMS-855A change request because X is under the provider’s LBN and TIN. Assume now that X seeks to enroll an ASC under X’s LBN and TIN. The exclusion would have to be reported in section 3 of the ASC’s initial Form CMS-855B.

Example (c) – Company Y is listed as the provider/supplier for two HHAs and two suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS). These four providers/suppliers are under Y’s LBN and TIN. Each provider/supplier is located in a different State. All are enrolled. Y’s billing privileges for one of the DMEPOS suppliers are revoked due to a felony conviction. Y now seeks to enroll an ASC in a fifth State. Y must disclose its felony conviction even though the felony conviction occurred in a state different from that in which the ASC is located.

3. Timeframe – With the exception of felony and misdemeanor convictions all other final adverse actions must be reported in the final adverse legal action of the Form CMS-855 or Form CMS-20134, all final adverse actions must be reported regardless of when the final adverse legal action occurred.

4. Evidence to Indicate Final Adverse Action – There may be instances where the provider or supplier states on Form-855 or Form CMS-20134 that the person or entity has never had a final adverse action imposed against him/her/it, but the contractor finds evidence to indicate otherwise. In such cases, the contractor shall follow the decision tree in section 15.5.3.1.

Note that MDPP suppliers enrolling through the CMS-20134 are not required to submit any final adverse action as it relates to MDPP coaches submitted on Section 7 of that form.

F. Reportable Final Adverse Actions

Providers and suppliers shall disclose all reportable Final Adverse Actions on their enrollment applications. To satisfy the reporting requirement the provider or supplier shall complete the Final Adverse Legal Action section(s) (Form CMS-855 or Form CMS-20134) in its entirety and attach all applicable documentation concerning the adverse action, to the application. It shall be noted that all final adverse actions must be reported, regardless of whether any records have been expunged or pending appeal.

Reportable Final Adverse Actions that must be disclosed on the Form CMS-855 or Form CMS-20134 include:

1. Felony conviction(s) within 10 years

- Providers are required to report a felony (Federal or State) when—
 - A conviction has occurred; and
 - The felony judgment (disposition) date is within 10 years, from the submission date of a Form CMS-855 or Form CMS-20134 application.
- A conviction has occurred when a judgment has been entered against an individual/entity by a judge/jury or the court has accepted a plea of guilty or nolo contendere.
- A felony conviction shall be reported even if the conviction has been sealed, expunged or there is an appeal or post-trial motion pending.

2. Misdemeanor Conviction Within 10 years

- Report a misdemeanor conviction (Federal or State) when—

- A conviction has occurred; and
- The misdemeanor judgment (disposition) date is within 10 years, from the submission date of an Form CMS-855 or Form CMS-20134 application, and
- The misdemeanor is related to:
 - The delivery of an item/service under Medicare or a State health care item/service
 - The abuse or neglect of a patient in connection with the delivery of a health care item or service
 - Theft, Fraud, Embezzlement, breach of fiduciary duty or other financial misconduct in connection with the delivery of health care item/service
 - The interference with or obstruction of any investigation into any criminal offense
 - The unlawful manufacture, distribution, prescription or dispensing of a controlled substance
- A conviction has occurred when a judgment has been entered against an individual/entity by a judge/jury or the court has accepted a plea of guilty or nolo contendere.
- A misdemeanor conviction shall be reported even if the conviction has been sealed, expunged or there is an appeal or post-trial motion pending.

3. Current or Past Suspension(s)/Revocations(s) of a medical license

- A medical license board suspends or revokes a medical license for any period of time.

4. Current or Past Suspensions(s)/Revocation(s) of an accreditation

- An accrediting body suspends or revokes an accreditation for any period of time.

5. Current or Past Suspension(s) or Exclusion(s) imposed by the U.S. Department of Health and Human Service's Office of Inspector General (OIG)

- Items/services furnished, ordered or prescribed by a specified individual/entity are not reimbursed under Medicare, Medicaid and/or all other Federal health care programs until the individual or entity is reinstated by the HHS OIG.

6. Current or Past Debarment(s) from participation in any Federal Executive Branch procurement or non-procurement program

- An individual or entity is suspended throughout the Executive Branch or the Federal government, as it applies to procurement and non-procurement programs. An individual or entity will not be solicited from, contracts will not be awarded to or existing contracts

will not be renewed or otherwise extended to those individuals or entities with a debarment. (e.g. GSA debarment)

7. Medicaid exclusion(s), revocation(s) or termination(s) of any billing number

- A state terminates an active provider agreement or prohibits a provider from enrolling in the Medicaid program. Any Medicaid terminations should be forwarded to EnrollmentReview@cms.hhs.gov for review by PEOG.

G. Reviewing for Adverse Legal Actions

The contractor shall address the reporting of Adverse Legal Actions (ALA) in its review of initial enrollment, revalidation, reactivation or change of information applications submitted by a provider or supplier. The contractor may receive information of ALA not yet reported by the provider or supplier from CMS, other contractors or through the application screening process. The contractor shall consider this information and take action as described in (but not limited to) sections 15.5.3 and 15.27 of this chapter.

Providers and suppliers shall include all reportable ALAs on their enrollment applications. This information must be reported either at the time of the initial/revalidation application by the provider/supplier, or must be reported by the provider/supplier within the reporting requirements as specified in 42 CFR § 424.516 and section 15.10.1 of this chapter. Reportable ALAs include criminal convictions within the last 10 years, Federal Health Care programs exclusions/debarments, and revocation/suspension of a license to provide health care by any State licensing authority. Non-reportable ALAs include, but are not limited to, probations and malpractice suits. The contractors shall refer to 42 CFR 424.535 § (a)(2), 42 CFR 424.535 § (a)(3), 42 CFR §1001.2 and the CMS-855 forms for further clarification of what ALAs are to be reported. All applicable ALAs shall be reported, regardless of whether any records were expunged, pending appeals, or waivers being granted.

In order to assist a contractor in determining what actions to take when an ALA is involved, CMS has produced an ALA Decision Tree (see below) for the contractor to use as a guide. The contractor shall follow the ALA Decision Tree when they receive ALA information regarding a provider or supplier, and validate this information against the provider/supplier enrollment application. The contractor shall follow the ALA Decision Tree and shall not develop to the provider or supplier for reported or unreported ALA(s).

I. INITIAL/ REACTIVATION APPLICATIONS

Any actionable ALA reported by a provider shall result in the denial of an application. A MAC shall not develop the ALA. A MAC shall then continue evaluating all ALAs reported and not reported.

1.1 LICENSURE – INITIAL/REACTIVATION APPLICATIONS

| Provider holds a valid accreditation/medical license in the state in which they are enrolling | Did the provider report the ALA taken on their license/ accreditation? | MAC Action | Notes |
|--|--|---|---|
| Provider's accreditation/medical license was previously suspended / revoked / voluntarily surrendered while formal disciplinary proceeding was pending before a State licensing authority. | Yes | Process application unless there is another reported adverse legal action that precludes the processing of the application. Refer to section(s) 1.2 – 1.8. | MACs shall read board orders thoroughly to determine if there are other adverse actions associated with the license suspension/revocation. e.g. Felonies. |
| Provider's accreditation/medical license was previously suspended/revoked/ voluntarily surrendered while formal disciplinary proceeding was pending before a State licensing authority. | No | Deny application under 42 CFR § 424.530 (a)(4) unless the license adverse action occurred more than ten years prior to the date of application receipt. If a license suspension/revocation /surrender in lieu of disciplinary proceedings occurred more than ten years prior to the date of application receipt, the application and ALA information shall be sent to EnrollmentReview@cms.hhs.gov for review and decision. | <p>42 CFR § 424.530 (a)(4) shall ONLY be included as a denial reason, if the provider has never reported this adverse action.</p> <p>MACs shall consider whether other denial reasons exist. Refer to section (s) 1.2 – 1.8.</p> <p>MACs shall read board orders thoroughly to determine if there are other adverse actions associated with the license suspension/ revocation. e.g. Felonies</p> <p>No Reporting Requirement:</p> <ul style="list-style-type: none"> • A suspension is “stayed” in its entirety. • Advertising/Administrative penalties • Fines, Violations, Stipulations, Reprimands |

1.2 FELONIES – INITIAL/REACTIVATION APPLICATIONS

| Felony | Did the provider report their felony? | MAC Action | Notes |
|--|---------------------------------------|---|---|
| Provider or someone with ownership interest and/or managing control has been adjudged guilty of a felony and/or a crime that is punished by imprisonment for a period of one year or more. | Yes or No | Send application and ALA information to ProviderEnrollmentRevolutions@cms.hhs.gov for review and decision. | All felony convictions shall be forwarded to CMS for review and decision. |

1.2 MISDEMEANORS – INITIAL/REACTIVATION APPLICATIONS

| Misdemeanor | Did the provider report their misdemeanor? | MAC Action | Notes |
|---|--|--|-------|
| Provider or someone with ownership interest and/or managing control has been adjudged guilty of a misdemeanor that is related to healthcare abuse or neglect of a patient, financial misconduct, interference with a criminal investigation, or unlawful manufacture, distribution or dispensing of a controlled substance. | Yes | Process application unless there is another reported adverse legal action that precludes the processing of the application. Refer to section(s) 1.1 & 1.3 – 1.8. | |
| Provider or someone with ownership interest and/or managing control has been adjudged guilty of a misdemeanor that is related to healthcare abuse or neglect of a patient, financial misconduct, interference with a criminal investigation, or unlawful manufacture, distribution or dispensing of a controlled substance. | No | Send ALA information to ProviderEnrollmentRevolutions@cms.hhs.gov for review and decision. | |

1.3 EXCLUSION (ACTIVE) – INITIAL/REACTIVATION APPLICATIONS

| Current Exclusion | Did the provider report their current exclusion? | MAC Action | Notes |
|--|--|---|---|
| Provider or someone with ownership interest and/or managing control has an active HHS and/or OIG exclusion | Yes | Deny application under 42 CFR § 424.530 (a)(2) | MACs shall consider whether other denial reasons exist. Refer to section(s) 1.1 – 1.2 & 1.4 - 1.8. A waiver does not guarantee automatic enrollment into the Medicare program. All waivers shall be sent to ProviderEnrollmentRevocations@cms.hhs.gov for review. |
| Provider or someone with ownership interest and/or managing control has an active HHS and/or OIG exclusion | No | Deny application under 42 CFR § 424.530 (a)(2) & (a)(4) | 42 CFR § 424.530 (a)(4) shall ONLY be included as a denial reason, if the provider has never reported this adverse action. However § 424.530 (a)(2), in this particular scenario, would still be apply. |

1.4 EXCLUSION (EXPIRED) – INITIAL/REACTIVATION APPLICATIONS

| Exclusion period has expired | Did the provider report their past | MAC Action | Notes |
|--|---|--|--|
| Provider or someone with ownership interest and/or managing control has a HHS and/or OIG exclusion has been reinstated by HHS and/or OIG. | Yes | Process application unless there is another reported adverse legal action that precludes the processing of the application. Refer to section(s) 1.1 – 1.3 & 1.5 – 1.8. | |
| Provider or someone with ownership interest and/or managing control has a HHS and/or OIG exclusion period has expired and provider/supplier has been reinstated by HHS and/or OIG. | No | Deny application under 42 CFR § 424.530 (a)(4) unless the provider was reinstated more than ten years prior to the date of application receipt. If a provider has been reinstated more than ten years prior to the date of application receipt, the application and ALA information shall be sent to ProviderEnrollmentRevocations@cms.hhs.gov for review and decision. | MACs shall consider whether other denial reasons exist. Refer to section(s) 1.1 – 1.3 & 1.5 – 1.8. 42 CFR § 424.530 (a)(4) shall ONLY be included as a denial reason, if the provider has never reported this adverse |

1.5 MEDICARE PAYMENT SUSPENSION (CURRENT) – INITIAL/REACTIVATION APPLICATIONS

| Medicare Payment Suspension is currently active | Did the provider report their current Medicare Payment Suspension? | MAC Action | Notes |
|--|---|---|---|
| Current Medicare Payment Suspension | Yes or No | Process application unless there is another reported adverse legal action that precludes the processing of the application. Refer to section(s) 1.1 – 1.4 & 1.6- 1. 8 | Providers are NOT required to report Current or Past Medicare Payment Suspensions to CMS. MACs shall consider whether other denial reasons exist. Refer to section(s) 1.1 |

1.6 MEDICARE PAYMENT SUSPENSION (PAST) – INITIAL/REACTIVATION APPLICATIONS

| Medicare Payment Suspension that is NOT currently active | Did the provider report their past Medicare Payment Suspension? | MAC Action | Notes |
|---|--|--|---|
| Past Medicare Payment Suspension | Yes or No | Process application unless there is another reported adverse legal action that precludes the processing of the application. Refer to section(s) 1.1 – 1.5 & 1.8. | Providers are NOT required to report Current or Past Medicare Payment Suspensions to CMS. MACs shall consider whether other denial reasons exist. Refer to section(s) 1.1 – 1.5 & 1.7, 1.8. |

1.7 MEDICARE REVOCATION – INITIAL/REACTIVATION APPLICATIONS

| Medicare Revocation | Did the provider report their Medicare | MAC Action | Notes |
|--|--|--|--|
| All prior enrollment bar(s) have expired | Yes or No | Process application unless there is another reported adverse legal action that precludes the processing of the application. Refer to section(s) 1.1 – 1.6, 1.8. | Providers are NOT required to report Current or Past Medicare Revocations to CMS. MACs shall consider whether other denial reasons exist. Refer to section(s) 1.1 – 1.6, 1.8. |
| Enrollment bar is active in the state that the provider is enrolling | Yes or No | Return the application | |
| Enrollment bar is active in a state other than the enrolling state | Yes or No | Return the application | |

1.8 FEDERAL SANCTION – INITIAL/REACTIVATION APPLICATIONS

| Federal Sanction | Did the provider report their Federal Sanction? | MAC Action | Notes |
|---|---|---|--|
| The provider has a current or past federal sanction | Yes | Process application unless there is another reported adverse legal action that precludes the processing of the application. Refer to section(s) 1.1 – 1.7. | |
| The provider has a current or past federal sanction | No | MACs are only required to verify via SAM/OIG. If encountered here or otherwise, MAC shall send the application and ALA information to EnrollmentReview@cms.hhs.gov for review and decision. | MACs shall consider whether other denial reasons exist. Refer to section(s) 1.1 – 1.7. |

II. REVALIDATIONS/CHANGE OF INFORMATION APPLICATIONS

Any actionable ALA reported by a provider shall result in a revocation. A MAC shall not develop the ALA. If a MAC discovers an ALA that has not been reported by a provider, a MAC shall record the ALA in Section 3 of PECOS and note that they were the entity that discovered the ALA. A MAC shall then continue evaluating all ALAs reported and not reported

2.1 LICENSURE – REVALIDATIONS/ CHANGE OF INFORMATION APPLICATIONS

| Provider holds a valid accreditation/medical license in the state in which they are revalidating or changing information. | Did the provider report the ALA taken on their license/ accreditation? | MAC Action | Notes |
|---|--|--|---|
| <p>Provider’s accreditation/ medical license was previously suspended/revoked/ voluntarily surrendered while formal disciplinary proceeding was pending before a State licensing authority.</p> | <p>Yes</p> | <p>MACs shall check whether the provider billed for dates of service during the period of license suspension/revocation/surrender during disciplinary proceedings. If the provider billed for dates of service during this period, the MACs shall send the application and ALA information to ProviderEnrollmentRevocations@cms.hhs.gov.</p> <p>If the provider did not bill during the period of license suspension, the application shall be processed unless there is another reported adverse legal action that precludes the processing of the application. Refer to sections 2.2 – 2.8.</p> | <p>MACs shall read board orders thoroughly to determine if there are other adverse actions associated with the license suspension/ revocation/ surrender. E.g.Felonies.</p> |

2.1 LICENSURE – REVALIDATIONS/ CHANGE OF INFORMATION APPLICATIONS

| | | | |
|--|----|---|--|
| Provider's accreditation/ medical license was previously suspended/revoked/ voluntarily surrendered while formal disciplinary proceeding was pending before a State licensing authority. | No | <p>MACs shall check whether the provider billed for dates of service during the period of license suspension/revocation. If the provider billed for dates of service during this period, the MACs shall send the applications to ProviderEnrollmentRevocations@cms.hhs.gov.</p> <p>If the provider did not bill for dates of service during this period, the provider shall be revoked under 42 § 424.535(a)(4).</p> <p>If a license/suspension/revocation/ surrender in lieu of disciplinary proceeding occurred more than ten years prior to the date of application receipt, the application and ALA information shall be send to EnrollmentReview@cms.hhs.gov for review and decision.</p> | <p>42 CFR § 424.535 (a)(4) shall ONLY be included as a revocation reason, if the provider has never reported this adverse action.</p> <p>MACs shall read board orders thoroughly to determine if:</p> <ul style="list-style-type: none"> - there are other adverse actions associated with the license suspension/revocation/ surrender. e.g. Felonies <p>No Reporting Requirement:</p> <p>A suspension is “stayed” in its entirety.</p> <p>Advertising/Administrative penalties</p> <p>Fines, Violations, Stipulations, Reprimands</p> |
|--|----|---|--|

2.2 FELONIES — REVALIDATION/ CHANGE OF INFORMATION APPLICATIONS

| Felony | Did the provider report their felony? | MAC Action | Notes |
|---|---------------------------------------|---|---|
| Provider or someone with ownership interest and/or managing control has been adjudged guilty of a felony and/or a crime that is punishable by imprisonment. | Yes or No | Send application and ALA information to ProviderEnrollmentRevocations@cms.hhs.gov for review and decision. | All felonies shall be forwarded to CMS for review and decision. |

2.2 MISDEMEANORS – REVALIDATION/ CHANGE OF INFORMATION APPLICATION

| Misdemeanor | Did the provider report their misdemeanor? | MAC Action | Notes |
|--|--|---|-------|
| Provider or someone with ownership interest and/or managing control has been adjudged guilty of a misdemeanor that is related to healthcare, abuse or neglect of a patient, financial misconduct, interference with a criminal investigation, or un- lawful manufacture, distribution, prescription or dispensing of a controlled substance. | Yes | Process application unless there is another reported adverse legal action that precludes the processing of the application. Refer to section(s) 2.1 & 2.3 – 2.8. | |
| Provider or someone with ownership interest and/or managing control has been adjudged guilty of a misdemeanor that is related to healthcare, abuse or neglect of a patient, financial misconduct, interference with a criminal investigation, or un- lawful manufacture, distribution, prescription or dispensing of a controlled substance. | No | Send ALA information to ProviderEnrollmentRevocations@cms.hhs.gov for review and decision. | |

2.3 EXCLUSION (ACTIVE) – REVALIDATION/CHANGE OF INFORMATION APPLICATIONS

| Current Exclusion | Did the provider report their current exclusion? | MAC Action | Notes |
|---|---|---|--|
| Provider or someone with ownership interest and/or managing control has an active HHS and/or OIG exclusion. | Yes | Revoke provider under 42 CFR § 424.535 (a)(2) | MACs shall consider whether other revocation reasons exist. Refer to section(s) 2.1 – 2.2 & 2.4 - 2.8. All waivers should be sent to ProviderEnrollmentRevocations@cms.hhs.gov for review. |
| Provider or someone with ownership interest and/or managing control has an active HHS and/or OIG Exclusion. | No | Revoke provider under 42 CFR § 424.535 (a)(2) and (a)(4). | MACs shall consider whether other revocation reasons exist. Refer to section(s) 2.1 – 2.2 & 2.4 – 2.8. All waivers should be sent to ProviderEnrollmentRevocations@cms.hhs.gov for review 42 CFR § 424.535 (a)(4) shall ONLY be included as a revocation reason, if the provider has never reported this adverse action. However § 424.535 (a)(2), in this particular scenario, would still be apply. |

2.4 EXCLUSION (EXPIRED) – REVALIDATION/CHANGE OF INFORMATION APPLICATIONS

| Exclusion period has expired | Did the provider report their past exclusion? | MAC Action | Notes |
|--|--|---|--------------|
| Provider or someone with ownership interest and/or managing control has a HHS and/or OIG exclusion that has expired and has been reinstated by HHS and/or OIG. | Yes | Process application unless there is another reported adverse legal action that precludes the processing of the application. Refer to section(s) 2.1 – 2.3 & 2.5 – 2.8. | |

2.4 EXCLUSION (EXPIRED) – REVALIDATION/CHANGE OF INFORMATION APPLICATIONS

| | | | |
|--|----|---|--|
| Provider or someone with ownership interest and/or managing control has a HHS and/or OIG exclusion that has expired and has been reinstated by HHS and/or OIG. | No | Revoke provider under 42 CFR § 424.535 (a)(4) unless the provider was reinstated more than ten years prior to the date of application receipt. If a provider has been reinstated more than ten years prior to the date of application receipt, the application and ALA information shall be sent to EnrollmentReview@cms.hhs.gov for review and decision. | 42 CFR § 424.535 (a)(4) shall ONLY be included as a revocation reason, if the provider has never reported this adverse action. |
|--|----|---|--|

2.5 MEDICARE PAYMENT SUSPENSION (CURRENT) – REVALIDATION/CHANGE OF INFORMATION APPLICATIONS

| Medicare Payment Suspension that is currently active | Did the provider report their current Medicare Payment Suspension? | MAC Action | Notes |
|---|---|---|--|
| Current Medicare Payment Suspension | Yes or No | Process application unless there is another reported adverse legal action that precludes the processing of the application. Refer to section(s) 2.1 – 2.5 & 2.7. 2.8. | Providers are NOT required to report Current or Past Medicare Payment Suspensions. |

| 2.6 MEDICARE PAYMENT SUSPENSION (PAST) – REVALIDATION/CHANGE OF INFORMATION | | | |
|--|--|---|--|
| Medicare Payment Suspension that | Did the provider report their past Medicare Payment | MAC Action | Notes |
| Past Medicare Payment Suspension | Yes or No | Process application unless there is another reported adverse legal action that precludes the processing of the application. Refer to section(s) 2.1 – 2.5 & 2.7, 2.8. | Providers are NOT required to report Current or Past Medicare Payment Suspensions. |

| 2.7 MEDICARE REVOCATION – REVALIDATION/CHANGE OF INFORMATION APPLICATIONS | | | |
|--|---|--|--|
| Any Medicare Revocation | Did the provider report their Medicare Revocation? | MAC Action | Notes |
| All prior enrollment bar(s) have expired | Yes or No | Process application unless there is another reported adverse legal action that precludes the processing of the application. Refer to section(s) 2.1 – 2.6, 2.8. | Providers are not required to report Current or Past Medicare Revocations to CMS. MACs shall consider whether other revocation reasons exist. Refer 2.1 – 2.6, 2.8. |
| Enrollment bar is active in a state other than current state. | Yes or No | Process the application unless there is another reported adverse legal action that precludes the processing of the application. Refer to section(s) 2.1 – 2.6, 2.8 | Providers are not required to report Current or Past Medicare Revocations to CMS. MACs shall consider whether other revocation reasons exist. Refer 2.1 – 2.6, 2.8. |

2.8 FEDERAL SANCTION – REVALIDATION/CHANGE OF INFORMATION APPLICATIONS

| Federal Sanction | Did the provider report their Federal Sanction? | MAC Action | Notes |
|---|---|---|---|
| The provider has a current or past federal sanction | Yes | Process application unless there is another reported adverse legal action that precludes the processing of the application. Refer to section(s) 2.1 – 2.7. | |
| The provider has a current or past federal sanction | No | MACs are only required to verify via SAM/OIG. If encountered here or otherwise, MAC shall send the application and ALA information to EnrollmentReview@cms.hhs.gov for review and decision. | MACs shall consider whether other reasons exist. Refer to section(s) 1. |

10.6.7 – Owning and Managing Information

(Rev. 10524; Issued: 12-17-20; Effective: 11-13-20; Implementation: 11-13-20)

A. Owning and Managing Organizations

(This section only applies to the Organizational Ownership and/or Managing Control Section of the Forms CMS-855A, CMS-855B, CMS-855S and CMS-20134. It does not apply to the Form CMS-855L.)

1. Ownership Information Required in Forms CMS-855A, CMS-855B, CMS-855S and CMS-20134

All organizations that have any of the following must be listed in the Organizational Ownership and/or Managing Control section of the Form CMS-855 and CMS-20134.

2. 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 the Identifying Information 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 the Organizational Ownership and/or Managing Control section of the Form CMS-855 or CMS-20134 for additional information on indirect ownership.

3. 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 the Organizational Ownership and/or Managing Control section. This frequently will include banks, other financial institutions, and investment firms,

4. Partnerships

a. Any general partnership interest in the provider, regardless of the percentage. This includes:

(i) All interests in a non-limited partnership, and

(ii) all general partnership interests in a limited partnership.

b. 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 the Organizational Ownership and/or Managing Control section of the Form CMS-855 and CMS-20134, the provider must indicate the type(s) of organizational categories the reported entity falls into.

6. Governmental Entities Listed in the Identifying Information section

Governmental entities must be identified in the Organizational Ownership and/or Managing Control section even if they are already listed in the Identifying Information section.

7. Governmental and Tribal Organization Letter – Signature Requirements

For governmental and tribal organizations, the letter referred to in the Form CMS-855 instructions for the Organizational Ownership and/or Managing Control section 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.

8. Diagrams – In addition to completing the Organizational Ownership and/or Managing Control section:

- The provider must submit an organizational structure diagram/flowchart identifying all of the entities listed in this section and their relationships with the provider and each other. (This applies to the Form CMS-855A, CMS-855B, CMS-855S and CMS-20134.)
- If the provider is a skilled nursing facility (SNF) or Opioid Treatment Program (OTP), 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 the Organizational or Individual Ownership and/or Managing Control sections. 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 and CMS-20134 reactivations, and upon any contractor request.

9. Disregarded Entities

In general, a “disregarded entity” is a term the IRS uses for an LLC that – for federal tax purposes only – is effectively indistinguishable from its single owner/member. The LLC’s income and expenses are shown on the owner’s personal tax return. The LLC itself does not pay taxes.

If an enrolling provider claims that it is a disregarded entity, the contractor need not obtain written confirmation of this from the provider notwithstanding the instruction in the Supporting Documents section of the Form CMS-855 or CMS-20134 that such confirmation is required. As a disregarded entity does not receive a CP-575 form from the IRS confirming its legal business name (LBN) and tax identification number (TIN), the contractor may accept from the enrolling provider any government form (such as a W-9) that lists its LBN and TIN. The disregarded entity’s LBN and TIN shall be listed in the Identifying Information/Business Information section of the Form CMS-855.

10. Ownership Information Furnished by the Provider Upon a Request by the Contractor (Applies to Forms CMS-855A, CMS-855B, CMS-855S, and CMS-20134)

a. 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.

b. Proof of Ownership 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.

c. Governmental and tribal entities

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.

d. Ownership Information Not Required in Forms CMS-855A, CMS-855B, CMS-855S and CMS-20134

i. Percentage of Interest (Organizational Ownership and/or Managing Control section)

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.

ii. Entities Listed Under the Identifying Information section of the Forms CMS-855A, CMS-855B and CMS-20134

Any entity listed as the provider in the Identifying Information section of the Form CMS-855A, CMS-855B and CMS-20134 need not be reported in the Organizational Ownership and/or Managing Control section. The only exception involves governmental entities, which must be identified in the Organizational Ownership and/or Managing Control section even if they are already listed in the Identifying Information section.

iii. Partnership Interests – Indirect Owners

Only partnership interests in the enrolling provider need be disclosed in the Organizational Ownership and/or Managing Control section. 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 this section.

B. Owning and Managing Individuals

(This section applies to the Individual Ownership and/or Managing Control section of the Form CMS-855A, the Form CMS-855B, the Form CMS-855I, the Form CMS-855S and Form CMS-20134.)

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

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

- A 5 percent or greater direct or indirect ownership interest in the provider.
- A 5 percent or greater mortgage or security interest in the provider.

(See section 10.6.7(A)(2) of this chapter for more information on direct and indirect ownership, and on mortgage and security interests.)

2. Any general partnership interest in the provider, regardless of the percentage, which include:

- All interests in a non-limited partnership, and
- All general partnership interests in a limited partnership.

3. Limited partnerships,

For the CMS-855A, limited partnerships, any limited partnership interest that is 10 percent or greater. Any percentage of partnerships must be reported in the CMS-855B, CMS-855S and CMS-20134.

4. Managing control of the provider.

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

5. Officers and directors/board members

Officers and directors/board members are required to be listed in the Individual Ownership and/or Managing Control section if – and only if - the applicant is a

corporation. (For-profit and non-profit corporations must list all of their officers and directors. If a non-profit corporation has “trustees” instead of officers or directors, these trustees must be listed in this section of the Form CMS-855A, CMS-855B, CMS-855S and CMS-20134.) Only officers and directors of the enrolling provider must be reported. Board members of the provider’s indirect owners need not be disclosed to the extent they are not otherwise required to be reported (e.g., as an owner or managing employee) in this section. However, there may be situations where the officers and directors/board members of the enrolling provider’s corporate owner/parent also serve as the enrolling provider’s officers and directors/board members. In such cases – and again assuming that the provider is a corporation – the indirect owner’s officers and directors/board members would have to be disclosed as the provider’s officers and directors/board members in this section.

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

6. Partners

Partners are required to be listed in the Individual Ownership and/or Managing Control section of the CMS-855A, CMS-855B, CMS-855S and CMS-20134.

7. Additional Information Regarding Owning and Managing Individuals in the Individual Ownership and/or Managing Control section

- The provider need not disclose a percentage of: (1) control as an officer or director, (2) W-2 or contracted managerial control, or (3) operational control. Also, the provider need not submit documentation verifying the percentage of ownership, partnership interest or security/mortgage interest, unless the contractor requests it.
- Government entities need only list their managing employees in the Individual Ownership and/or Managing Control section of the Form CMS-855, as they do not have owners, partners, corporate officers, or corporate directors.
- The applicant must list at least one managing employee in the Individual Ownership and/or Managing Control section if it is completing the Form CMS-855A, Form CMS-855B, CMS-855S or CMS-20134. An individual completing the Form CMS-855I need not list a managing employee if he/she does not have one.
- All managing employees at any of the practice locations listed in the Business Information/Practice Location Information section of the Form CMS-855I must be reported in the Managing Employee Information section. However, individuals who: (1) are employed by hospitals, health care facilities, or other

organizations shown in the Business Information/Practice Location Information section (e.g., the chief executive officer of a hospital listed in this section), or (2) are managing employees of any group/organization to which the practitioner will be reassigning his/her benefits, need not be reported.

- The contractor need not request a copy of the individual's W-2 to confirm that he/she is a W-2 employee (as opposed to a contracted employee), although it reserves the right to do so.
- Proof of ownership, managerial control, security interests, etc., need not be submitted unless the contractor requests it.
- Only partnership interests in the enrolling provider need be disclosed. Partnership interests in the provider's indirect owners need not be reported. Of course, 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 the Individual Ownership and/or Managing Control section.

See section 10.6.7(C) of this chapter for special instructions regarding the reporting of tax identification numbers of owning and managing individuals.

C. Tax Identification Numbers (TINs)

This section provides information regarding TINs of Owning and Managing Organizations and Individuals

1. TIN Disclosure Requirements for Form CMS-855

Consistent with sections 1124 and 1124A of the Social Security Act, the TINs (employer identification numbers or social security numbers) of all entities and individuals listed in the Organizational and Individual Ownership and/or Managing Control sections, of the Form CMS-855 must be disclosed. If the contractor receives an initial, reactivation, revalidation, or change of ownership application from a provider and the provider fails to disclose the TIN of a particular organization or individual listed in the Organizational or Individual Ownership and/or Managing Control sections, the contractor shall follow normal development procedures for requesting the TIN.

2. Documentation of TIN and/or LBN

When documentation of the provider's or supplier's TIN and/or LBN is required, the contractor may accept a CP-575, a federal tax department ticket, or any other pre-printed document from the IRS that identifies the TIN and/or LBN.

3. TIN Disclosure Requirements for Individuals Who Do Not Have, and are Not Eligible to Obtain, a Social Security Number (SSN) from the Social Security Administration (SSA)

In following the normal development procedures for requesting a TIN, if the contractor learns or determines that the TIN was not furnished because the entity or person in question is not eligible to obtain a SSN from the SSA, the contractor shall take the following steps:

a. Development

The contractor shall ask the provider (via any means) whether the person or entity is able to obtain a TIN or, in the case of individuals, an individual taxpayer identification number (ITIN). (Only one inquiry is needed.)

- i. If the provider fails to respond to the contractor's inquiry within 30 days, the contractor shall follow the instructions in (c) below.
- ii. If the provider states that the person or entity is able to obtain a TIN or ITIN, the contractor shall send an e-mail, fax, or letter to the provider stating that (i) the person or entity must obtain a TIN/ITIN, and (ii) the provider must furnish the TIN/ITIN on the Form CMS-855 with a newly-signed certification statement within 90 days of the contractor's request.
- iii. If the provider states that the person or entity is unable to obtain a TIN or ITIN, the contractor shall send an e-mail, fax, or letter to the provider stating that (i) the provider must submit written documentation to the contractor explaining why the person or entity cannot legally obtain a TIN or ITIN, and (ii) the explanation – which can be in any written format and may be submitted electronically or via fax – must be submitted within 30 days of the contractor's request.

b. Referral to CMS

If the provider timely submits the explanation in (1)(a) above, the contractor shall forward the explanation to its CMS Provider Enrollment & Oversight Group Business Function Lead (PEOG BFL). PEOG will notify the contractor as to how the application should be handled.

c. Failure to timely respond

If the provider fails to timely respond to the contractor's inquiry in 10.6.7(C)(3)(a), the contractor shall – unless another CMS instruction directs otherwise - reject the application in accordance with the procedures identified in this chapter.

In addition:

- If the contractor exceeds timeliness standards on a particular application because of the procedures outlined in this section, the contractor shall document the provider file in accordance with section 10.6.19(I) of this chapter.

For purposes of this section 10.6(A) only, the term “change of ownership” - as used in the first paragraph of this section - refers to (1) CHOW, acquisition/merger, and consolidation applications submitted by the new owner, (2) change in majority ownership applications submitted by a home health agency, and (3) change of information applications in which a new entity or individual (e.g., owner, managing employee, corporate director) is being added in the Organizational or Individual Ownership and/or Managing Control sections.

4. Provider or Supplier That is Changing its TIN

If a provider or supplier is changing its TIN, the transaction shall be treated as a brand new enrollment as opposed to a change of information. Consequently, the provider or supplier must complete a full Form CMS-855 or CMS-20134 and a new enrollment record must be created in PECOS.

10.6.8 – Billing Agencies

(Rev. 10524; Issued: 12-17-20; Effective: 11-13-20; Implementation: 11-13-20)

(Unless otherwise stated, this section applies to the Form CMS-855A, the Form CMS-855B, the Form CMS-855I, CMS-855S and the Form CMS-20134 or applications submitted via Internet-Based PECOS.)

A billing agency is an entity that furnishes billing and collection services on behalf of a provider or supplier. A billing agency is not enrolled in the Medicare program. A billing agency submits claims to Medicare in the name and billing number of the provider or supplier that furnished the service or services. In order to receive payment directly from Medicare on behalf of a provider or supplier, a billing agency must meet the conditions described in § 1842(b)(6)(D) of the Social Security Act.

The provider shall complete the Billing Agency section of the Forms CMS-855A, CMS-855B, CMS-855I, CMS-855S and CMS-20134 with information about all billing agents it utilizes. As all Medicare payments must be made via electronic funds transfer, the contractor need not verify the provider’s compliance with the “Payment to Agent” rules in CMS Publication 100-04, chapter 1, section 30.2. The only exception is if the contractor discovers that the “special payments” address in the Practice Location section of the provider’s Form CMS-855 or CMS-20134 application belongs to the billing agent or agency. In this situation, the contractor may obtain a copy of the billing agreement if it has reason to believe that the arrangement violates the “Payment to Agent” rules.

Note: the billing agency address can be listed as a PO Box on paper Form CMS-855 and CMS-20134 applications.

For further information on billing agencies, see CMS Publication 100-04, chapter 1, section 30.2.4.

10.6.9 – Contact Persons

(Rev. 10524; Issued: 12-17-20; Effective: 11-13-20; Implementation: 11-13-20)

Unless stated otherwise in this chapter or in another CMS directive - or unless the provider requests that the contractor communicate with only a specific individual (e.g., an authorized official) or via specific means (e.g., only via the correspondence address e-mail) - the contractor has the discretion to use the contact persons collected via the Forms CMS-855A, CMS-855B, CMS-855I, CMS-855O, CMS-855R, CMS-855S and CMS-20134 for all written and oral communications (e.g., mail, e-mail, telephone) related to the provider's Medicare enrollment. Such communication need not be restricted to a particular enrollment application of the provider's that the contractor is currently processing. Nor is the contractor required (again, unless either CMS or the provider directs otherwise) to send certain materials to the correspondence mailing or e-mail address rather than the contact person's mailing or e-mail address.

The provider may have as many contact persons as it wishes.

If the contractor discovers that a particular contact person qualifies as an owning or managing individual, the provider shall list the person in the Individual Ownership and/or Managing Control section of the application

If multiple contact persons are listed, the contractor has the discretion to select the individual to contact unless the provider indicates otherwise via any means. In addition:

- The contractor may use multiple contact persons throughout the enrollment process; it need not use the same individual for the entire duration unless, again, the provider indicates otherwise.
- All contact persons shall be stored in PECOS and shall not be removed unless the provider requests the removal via letter, e-mail, or fax. Currently, for forms without an option to delete a contact person contractors shall accept end dates of a contact person via phone, email, fax or mail from the individual provider, the Authorized or Delegation official, or a current contact person on file. Contractors shall document in the comment section in PECOS who requested the termination, how it was requested (email, phone or fax) and when it was requested. The addition of contact persons must still be reported via the appropriate CMS-855 form.

10.6.10 – Medicare Payment

(Rev. 10524; Issued: 12-17-20; Effective: 11-13-20; Implementation: 11-13-20)

A. Electronic Fund Transfers (EFT)

1. 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 or Form CMS-20134 before the contractor can effectuate the change.

With the exception of the situation described below, it is immaterial whether the provider or the bank was responsible for triggering a change to EFT data (e.g., bank routing number).

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

- 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 or who does not have the most current EFT form on file with the contractor and 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.
- For web-based application submissions, the form CMS-588 shall be submitted via PECOS upload functionality.

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

The contractor shall only assign the minimum number of PTANs necessary to ensure that proper payments are made. The contractor shall not assign additional PTAN(s) to a supplier merely because the individual or entity requests one - the only exception being for hospitals that request separate billing numbers for their hospital departments in the Identifying Information/Hospitals Only section of the Form CMS-855B. However, a hospital requesting an additional PTAN must associate the new PTAN with a National Provider Identifier in the Practice Location Information section of the Form CMS-855B.

C. NPI-Legacy Combinations

If the contractor determines that a provider is having claim payment issues due solely to an incorrect NPI-Provider Transaction Access Number (PTAN) combination or NPI-CMS Certification Number (CCN) combination entered into the Provider Enrollment, Chain and Ownership System (PECOS), the contractor shall request that the provider submit the correct NPI-legacy combination via a Form CMS-855 or CMS-20134 change of information. The change request can be faxed, although the contractor shall verify the faxed signature against the provider's or authorized official's signature on file before any changes are made in PECOS.

The contractor shall not use this process to resolve any enrollment issue other than the correction of the NPI-legacy identifier combination. Moreover, the contractor shall not use this process for providers that have not submitted a complete Form CMS-855 or CMS-20134 enrollment application during or after May 2006. For instance, assume a provider first enrolled in Medicare in December 2005 and has not submitted a complete enrollment application after that date. The provider would be unable to utilize the process described in this section.

10.6.11 – Participation (Par) Agreements and the Acceptance of Assignment – General Information **(Rev. 10524; Issued: 12-17-20; Effective: 11-13-20; Implementation: 11-13-20)**

All providers/suppliers must choose to be either Par or Non-Par when initially enrolling and must maintain the same Par status across all lines of business.

Individual physicians and non-physician practitioners who reassign benefits to a clinic/group practice inherit the Par status established by the clinic/group practice. However, if the individual physician or non-physician practitioner maintains a private practice, separate from the reassignment of benefits agreement, he/she may designate their own Par status. Refer to the instructions in Publication 100-04, chapter 1, section 30 for applying the correct Par status to clinic/group practices, organizations and individuals in private practice.

The contractor shall follow the instructions in CMS Publication 100-04, chapter 1, sections 30 through 30.3.12.3 when handling issues related to par agreements and assignment. Queries related to the interpretation of such instructions shall be referred to the responsible CMS component.

Physicians and Part B organizations should be entered as Par in PECOS based on the submission of a signed CMS-460 (Medicare Participating Physician or Supplier Agreement) upon initial enrollment or during a change to their Par status during the annual Medicare Open Enrollment period. Non-Physician Practitioners that are considered mandatory participation and individual physicians and non-physician practitioners that reassign all of their benefits to a Par organization should not be entered as Par in PECOS.

10.6.12 – Opting-Out of Medicare **(Rev. 10524; Issued: 12-17-20; Effective: 11-13-20; Implementation: 11-13-20)**

Normally physicians and practitioners are required to submit claims on behalf of beneficiaries for all items and services they provide for which Medicare payment may be made under Part B. Also, they are not allowed to charge beneficiaries in excess of the limits on charges that apply to the item or service being furnished.

However, certain types of physicians and practitioners may “opt-out” of Medicare. A physician or practitioner who opts-out is not required to submit claims on behalf of beneficiaries and also is excluded from limits on charges for Medicare covered

services. Medicare does not pay anyone for services (except for certain emergency and urgent care services) furnished by an opt-out physician or practitioner. Instead, opt-out physicians and practitioners sign private contracts with beneficiaries. Please refer to Pub. 100-02, Chapter 15, sections 40 – 40.39 for more information regarding maintaining opt-out affidavits and the effects of improper billing of claims during an opt-out period. The instruction included in this chapter is intended for processing opt-out affidavits by the Provider Enrollment staff at the Medicare Administrative Contractors (MACs).

A. Who May Opt-out of Medicare

Only certain physicians and non-physician practitioners (referred to as “eligible practitioners” in this section), but not organizations, can “opt-out” of Medicare.

Physicians who are:

- Doctors of medicine or osteopathy,
- Doctors of dental surgery or dental medicine,
- Doctors of podiatry, or
- Doctors of optometry who are legally authorized to practice dentistry, podiatry, optometry, medicine, or surgery by the State in which such function or action is performed.

Non-Physician Practitioners who are

- Physician assistants,
- Nurse practitioners,
- Clinical nurse specialists,
- Certified registered nurse anesthetists,
- Certified nurse midwives,
- Clinical psychologists,
- Clinical social workers, or
- Registered dietitians or nutrition professionals who are legally authorized to practice by the State and otherwise meet Medicare requirements.

This means that neither the eligible practitioner nor the beneficiary submits the bill to Medicare for services performed. Instead, the beneficiary pays the physician out-of-pocket and neither party is reimbursed by Medicare. In fact, a private contract is signed between the eligible practitioner and the beneficiary that states, in essence, that neither one can receive payment from Medicare for the services that were performed. (The contract, of course, must be signed before the services are provided so the beneficiary is fully aware of the physician’s opt-out status.) Moreover, the eligible practitioner must submit an affidavit to Medicare expressing his/her decision to opt-out of the program. The provider enrollment unit must process these affidavits.

Eligible Practitioners that opt-out of Medicare are not the same as non-participating physicians/suppliers. Non-participating physicians/suppliers are enrolled in Medicare and choose on a claim-by-claim basis whether they want to accept assignment unless the service can only be paid on an assignment related basis as required by the law (e.g.,

for drugs, ambulance services, etc.). Therefore, non-participating physicians/suppliers must comply with Medicare's mandatory claim submission, assignment, and limiting charge rules. Conversely, opt-out physicians/practitioners are excused from the mandatory claim submission, assignment, and limiting charge rules but **only** when they maintain compliance with all of the requirements for opting out.

In an emergency care or urgent care situation, an eligible practitioner who has opted-out may treat a Medicare beneficiary with whom he or she does not have a private contract. In those circumstances, the eligible practitioner must complete a CMS-855 application.

B. Requirements for an Opt-out Affidavit

As stated in Pub. 100-02, Chapter 15, Section 40.9, the affidavit shall state the following, that upon signing the affidavit, the eligible practitioner agrees to the following requirements:

- Except for emergency or urgent care services, during the opt out period the eligible practitioner will provide services to Medicare beneficiaries only through private contracts, but for their provision under a private contract, would have been Medicare-covered services;
- The eligible practitioner will not submit a claim to Medicare for any service furnished to a Medicare beneficiary during the opt out period, nor will the eligible practitioner permit any entity acting on the eligible practitioner's behalf to submit a claim to Medicare for services furnished to a Medicare beneficiary;
- During the opt out period, the eligible practitioner understands that he/she may receive no direct or indirect Medicare payment for services that the eligible practitioner furnishes to Medicare beneficiaries with whom the eligible practitioner has privately contracted, whether as an individual, an employee of an organization, a partner in a partnership, under a reassignment of benefits, or as payment for a service furnished to a Medicare beneficiary under a Medicare Advantage plan;
- An eligible practitioner who opts out of Medicare acknowledges that, during the opt out period, the eligible practitioner's services are not covered under Medicare and that no Medicare payment may be made to any entity for the eligible practitioner's services, directly or on a capitated basis;
- On acknowledgment by the eligible practitioner to the effect that, during the opt out period, the eligible practitioner agrees to be bound by the terms of both the affidavit and the private contracts that the eligible practitioner has entered into;
- Acknowledge that the eligible practitioner recognizes that the terms of the affidavit apply to all Medicare-covered items and services furnished to

Medicare beneficiaries by the eligible practitioner during the opt out period (except for emergency or urgent care services furnished to the beneficiaries with whom the eligible practitioner has not previously privately contracted) without regard to any payment arrangements the eligible practitioner may make;

- With respect to an eligible practitioner who has signed a Part B participation agreement, acknowledge that such agreement terminates on the effective date of the affidavit;
- Acknowledge that the eligible practitioner understands that a beneficiary who has not entered into a private contract and who requires emergency or urgent care services may not be asked to enter into a private contract with respect to receiving such services;
- Identify the eligible practitioner sufficiently so that the Medicare contractor can ensure that no payment is made to the eligible practitioner during the opt-out period; and
- Be filed with all MACs who have jurisdiction over claims the eligible practitioner would otherwise file with Medicare, and 42 CFR §405.420 the initial 2-year opt-out period will begin the date the affidavit meeting the requirements of is signed, provided the affidavit is filed within 10 days after the eligible practitioner signs his or her first private contract with a Medicare beneficiary.

MACs shall review initial opt-out affidavits to ensure that they contain the following information in order to create an affidavit record in PECOS:

The eligible practitioner's personal information:

- Full name (first, middle and last),
- Birthdate,
- Address and telephone number,
- License information and
- NPI (if one has been obtained), and
- SSN (if no NPI has been issued, NOTE: this cannot be an Individual Tax Identification Number or ITIN).

If MACs need to obtain any data that may be missing in an affidavit, in order to create a PECOS affidavit record, they may obtain that information from other sources (such as the state license board) or they should contact the eligible practitioner only **one time** directly. Contractors shall **not** use Internet-Based PECOS or the CMS 855 form to obtain the information from the eligible practitioner, as the eligible practitioner **is not** enrolling in Medicare. If the eligible practitioner is requested to submit missing information to allow for processing of the affidavit and fails to do so within 30 days, the MAC shall reject the opt-out affidavit.

1. Opting-out and Ordering and Referring

If an eligible practitioner that wishes to opt-out elects to order and refer items and services, the MACs shall develop for the following information (if not provided on the affidavit):

- An NPI (if one is not contained on the affidavit voluntarily);
- Date of Birth, and;
- SSN (if not contained on the Affidavit, this cannot be an ITIN).

Note: MACs shall review the List of Excluded Individuals and Entities (LEIE) on the OIG's website and the Excluded Parties List on the GSA's System for Award Management (SAM) for all eligible practitioners that submit opt-out affidavits. Excluded eligible practitioners may opt-out of Medicare, but cannot order or refer.

If the information listed above is requested but not received, the eligible practitioner's affidavit can be processed, but the eligible practitioner cannot be listed as an ordering and referring provider.

As noted in Section 10.4(M)(3)(e) of this chapter, individuals who are revoked from Medicare will not be able to order, certify or prescribe Part A or B Services, items, or drugs to Medicare beneficiaries if they opt-out of Medicare after revocation.

2. Acceptable Opt-out Affidavit Formats

MACs may provide a sample opt-out affidavit form for eligible practitioners to complete. The opt-out affidavit form must provide spaces for the eligible practitioners to provide their personal information.

Eligible practitioners may also create their own affidavit. If the practitioner elects to do so, he/she should include information found in Section 10.6.12(B)(2) to ensure timely processing of their opt-out affidavit.

a. Opt Out Affidavit Sample Form

MACs and eligible practitioners may use the information below as their opt-out affidavit form.

I, {Enter Physician/Non-Physician Practitioner Name}, being duly sworn, depose and say:

- Opt-out is for a period of two years. At the end of the two year period, my opt-out status will automatically renew. If I wish to cancel the automatic extension, I understand that I must notify my Medicare Administrative Contractor (MAC) in writing at least 30 days prior to the start of the next two-year opt- out period.

- Except for emergency or urgent care services (as specified in the Medicare Benefit Policy Manual Publication 100-02, Chapter 15 §40.28), during the opt-out period I will provide services to Medicare beneficiaries only through private contracts that meet the criteria of §40.8 for services that, but for their provision under a private contract, would have been Medicare-covered services.
- I will not submit a claim to Medicare for any service furnished to a Medicare beneficiary during the opt-out period, nor will I permit any entity acting on my behalf to submit a claim to Medicare for services furnished to a Medicare beneficiary, except as specified in §40.28.
- During the opt-out period, I understand that I may receive no direct or indirect Medicare payment for services that I furnish to Medicare beneficiaries with whom I have privately contracted, whether as an individual, an employee of an organization, a partner in a partnership, under a reassignment of benefits, or as payment for a service furnished to a Medicare beneficiary under Medicare Advantage.
- I acknowledge that during the opt-out period, my services are not covered under Medicare and that no Medicare payment may be made to any entity for my services, directly or on a capitated basis.
- I acknowledge and agree to be bound by the terms of both the affidavit and the private contracts that I have entered into during the opt-out period.
- I acknowledge and understand that the terms of the affidavit apply to all Medicare-covered items and services furnished to Medicare beneficiaries by myself during the opt-out period (except for emergency or urgent care services furnished to the beneficiaries with whom I have not previously privately contracted) without regard to any payment arrangements I may make.
- I acknowledge that if I have signed a Part B participation agreement, that such agreement terminates on the effective date of this affidavit.
- I acknowledge and understand that a beneficiary who has not entered into a private contract and who requires emergency or urgent care services may not be asked to enter into a private contract with respect to receiving such services and that the rules of §40.28 apply if I furnish such services.
- I have identified myself sufficiently so that the MAC can ensure that no payment is made to me during the opt-out period. If I have already enrolled in Medicare, I have included my Medicare PTAN, if one has been assigned. If I have not enrolled in Medicare, I have included the information necessary to opt-out.

- I will file this affidavit with all MACs who have jurisdiction over claims that I would otherwise file with Medicare and the initial two- year opt-out period will begin the date the affidavit meeting the requirements of 42 C.F.R. §405.420 is signed, provided the affidavit is filed within 10 days after the physician/practitioner signs his or her first private contract with a Medicare beneficiary.

Eligible practitioners should also be encouraged to include the following information (to complete an affidavit record in PECOS):

- Eligible Practitioner's NPI
- Eligible Practitioner's Medicare Identification Number (if issued)
- Eligible Practitioner's Social Security Number (not an ITIN)
- Eligible Practitioner's Date of Birth
- Eligible Practitioner's Specialty
- Eligible Practitioner's E-mail Address
- Eligible Practitioner's request to Order & Refer

3. Requirements of a Private Contract

In order to opt-out of Medicare, the eligible practitioner shall complete a “private contract” with their patients that are Medicare beneficiaries. Please refer to Pub. 100-02, Chapter 15, Section 40.8 for private contract definitions and requirements.

C. Determining an Effective Date of an Opt-out Period

As noted in Pub. 100-02, Chapter 15, Section 40.17, eligible practitioners receive effective dates based on their participation status.

1. Eligible practitioners that have never enrolled with Medicare

Eligible practitioners are not required to enroll prior to opting-out of Medicare. If a non-enrolled eligible practitioner submits an opt-out affidavit, the effective date of the opt-out period begins the date the affidavit is signed by the eligible practitioner.

2. Previously Enrolled Non-Participating Practitioners

If a previously enrolled eligible practitioner that is a non-participating physicians/suppliers decides to terminate their active Medicare billing enrollment and instead opt-out of Medicare, the effective date of the opt-out period begins the date the affidavit is signed by the eligible practitioner.

3. Previously Enrolled Participating Physicians/Suppliers

If a previously enrolled eligible practitioner that is a participating provider (one that accepts assignment for all their Medicare claims) decides to terminate his/her active Medicare billing enrollment and opt-out of Medicare, the effective date of the opt-out period begins the first day of the next calendar quarter. An opt-out affidavit must be received at least 30 days before the first day of the calendar quarter in order to receive January 1, April 1, July 1 or October 1 as their effective date. If the opt-out affidavit is received within 30 days prior to January 1, April 1, July 1 or October 1, the effective date would be the first day of the next calendar quarter. (For example, an enrolled participating eligible practitioner's opt-out affidavit was submitted on December 10th. The eligible practitioner's effective date could not be January 1, as the affidavit was not received 30 days prior to January 1. The effective date would be April 1.) The eligible practitioner would need to remain enrolled as a participating physician/supplier until the end of the next calendar quarter so that claims can be properly submitted until the opt-out period begins.

D. Emergency and Urgent Care Services

In the case that an eligible practitioner that has opted-out of Medicare provides emergency or urgent care services, that eligible practitioner must submit an application for enrollment via the Provider Enrollment Chain and Ownership System (PECOS) or a paper CMS-855I application. Once the eligible practitioner has received his/her Provider Transaction Access Number (PTAN), he/she must submit the claim(s) for any emergency or urgent care service provided. MACs shall contact their Provider Enrollment & Oversight Group Business Function Lead (PEOG BFL) for additional guidance when this type of situation arises. Please refer to Pub. 100-02, Chapter 15, Section 40.28 for more information on Emergency and Urgent Care Services.

E. Termination of an Opt Out Affidavit

As noted in Pub. 100-02, Chapter 15, Section 40.35, an eligible practitioner who has not previously opted-out may terminate their opt-out period early, however notification must be given to the MAC, in writing, signed by the eligible practitioner no later than 90 days after the effective date of the initial 2-year opt-out period. In order to properly terminate an affidavit, the eligible practitioner must:

1. Not have previously opted-out of Medicare (the eligible practitioner cannot terminate a renewal of his/her opt-out);
2. Notify all the MACs that the eligible practitioner has filed an affidavit no later than 90 days after the effective date of the affidavit;
3. Notify all beneficiaries (or their legal representation), that the eligible practitioner entered into private contracts with, of the eligible practitioner's decision to terminate their opt-out and of the beneficiaries' right to have claims filed on their behalf with Medicare for the services furnished during the period between the effective date of the opt-out and the effective date of the termination of the opt-out period and;

4. Refund to each beneficiary all payments collected in excess of the Medicare limiting charge or deductibles and coinsurance.

For eligible practitioners that were previously enrolled to bill Medicare for services, the MAC shall reactivate the eligible practitioner's enrollment record in PECOS and reinstate his/her PTAN as if no opt-out affidavit existed. The physician or NPP may bill for services provided during the opt-out period.

For eligible practitioners that were not previously enrolled to bill Medicare for services, the MAC shall remove the affidavit record from PECOS so that the eligible practitioner can submit the appropriate application(s) (via PECOS or paper CMS-855 for individual and/or reassignment enrollment) in order to establish an enrollment record in PECOS, so the physician or NPP may bill for services rendered during the opt-out period.

F. Opt-out Period Auto-Renewal and Cancellation of the Opt-out Affidavit

Eligible practitioners that initially opted-out or renewed an affidavit on or after June 16, 2015 need not submit a renewal of their affidavit. The opt-out will be automatically renewed for another 2 year period. However, if the eligible practitioner decides to cancel his/her opt-out, he/she must submit a written notice to each MAC to which he or she would file claims absent the opt-out, not later than 30 days before the end of the current 2 year opt-out period.

If the eligible practitioner decides to enroll in Medicare after his or her opt-out is canceled, he or she must submit an application via PECOS or a paper CMS-855I application. The effective date of enrollment cannot be before the cancellation date of the opt-out period. (For example, an eligible practitioner submits a cancellation of his or her opt-out to end the period on March 31, which is two years from the eligible practitioner's opt-out affidavit effective date. His/her requested Medicare effective date of enrollment cannot be before April 1.)

If the eligible practitioner submits a cancellation request within 30 days of the end of the current opt-out period or after the opt-out period automatically renews, MACs shall return the cancellation request to the eligible practitioner and provide appeal rights.

1. Opt-out Period Auto-Renewal Report and Opt-Out Renewal Alert

The MACs shall issue an Opt-Out Renewal Alert Letter (found in Section 10.7.13(F) of this chapter) to any eligible practitioners whose opt-out period is set to auto-renew.

To accomplish this, CMS will provide a monthly opt-out report to all contractors via the Share Point Ensemble site. The MACs shall access the report monthly through the Share Point Ensemble site. The MACs shall review the opt-out report for opted-out eligible practitioners that will auto-renew in the next 3 and a half months. MACs shall issue an Auto-Renewal Alert Letter to eligible practitioners at least 90 days prior to the auto-renewal date, so the eligible practitioner has at least 60 days prior to the date a cancellation notice must be submitted to cancel the current opt-out.

The Opt-out Auto-Renewal Alert Letter will provide the date the current opt-out period will be auto renewed and the date that the eligible practitioner will need to submit a cancellation request. The letter will provide the eligible practitioner appeal rights if he/she fails to submit a cancellation request and the opt-out renews.

The MACs shall complete the Opt-Out Renewal Alert Letter Report to include the date the Alert Letter was issued and post their reports no later than the 15th of the following month to the Share Point Ensemble site and email their PEOG BFL when the report has been posted.

If an eligible practitioner submits a CMS-855I and/or a CMS-855R (paper or web application) without submitting a cancellation request of his or her opt-out, the MACs shall issue a development for the cancellation notice. Once the cancellation notice is received, the MACs shall then process the application(s).

If the eligible practitioner submits a cancellation request within 30 days of the end of the current opt-out period or after the opt-out period automatically renews, MACs shall return the cancellation request to the eligible practitioner and provide appeal rights using the Late Cancellation Request return letter.

If the eligible practitioner submits a cancellation request more than 90 days prior to the auto-renewal date, MACs shall return the cancellation request to the eligible practitioner using the Cancellation Request Received Too Early return letter.

G. Opting-out vs. Enrolling for the Sole Purpose of Ordering and Referring and/or Prescribing

Physicians and certain non-physician practitioners (NPPs) who wish to enroll for the sole purpose of ordering and referring submit an application via PECOS or via the paper form CMS-855O application. These physicians and NPPs do not receive payments from Medicare, as they do not submit claims as performing providers.

An eligible practitioner that has opted out of Medicare does not need to additionally submit an application to enroll as an ordering and referring provider, if they indicate that they wish to order and refer (providing the necessary information on their affidavit as noted in Section 10.6.12(B)(2)).

H. Failure to Properly Cancel or Terminate Opt-out

Eligible practitioners that fail to properly cancel or terminate their opt-out shall be provided an opportunity to appeal the decision to continue the auto-renewal of the opt-out or continuation of the eligible practitioner's initial opt-out period.

The Opt-Out Approval letters include appeal rights for eligible practitioners that initially opt-out and fail to properly terminate the opt-out within 90 days of the approval.

10.6.13 – Ordering/Certifying Suppliers

A. Ordering/Certifying Suppliers– Background

1. Who Can Order/Certify

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

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

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

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

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

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

B. Requirements for Suppliers to Maintain Ordering and Certifying Documentation

1. Background

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

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

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

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

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

2. Contractors Requests for Documentation of Ordering or Certifying

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

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

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

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

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

Under §424.516(f), CMS or a Medicare contractor may request access to documentation described in §424.516(f). The term “access to documentation” means that the documentation is actually provided or made available in the manner requested by CMS or a Medicare contractor. All providers and suppliers who either furnish, order, or certify the items described in section 10.6.13(B)(1) are subject to

this requirement and are individually responsible for maintaining these records and providing them upon request.

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

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

Sufficient Access:

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

Deficient Access

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

CMS recognizes that providers and suppliers often rely upon an employer or another entity to maintain these records on their behalf. However, it remains the responsibility of the individual or entity upon whom/which the request has been made to provide documentation. All individuals and entities subject to this documentation requirement are responsible for ensuring that documents are provided upon request and may ultimately be subject to the revocation basis associated with not complying with the documentation request.

4. Process to Request Documentation of Ordering or Certifying

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

- Fails to respond within 30 calendar days of the contractor's request (i.e., a complete non-response), the contractor shall revoke enrollment using §424.535(a)(10) as the basis. Prior approval from the contractor's PEOG BFL is not necessary. A 1-year re-enrollment bar shall be imposed.
- Timely furnishes documentation that the contractor nevertheless deems inadequate, the contractor shall send a developmental letter via mail, e-mail or fax to the provider that requests more sufficient documentation. If the provider fails to submit such documentation (either via a complete non-response or by submitting additional inadequate documentation), the contractor shall refer the matter (including the documentation submitted to date) to its CMS PEOG BFL. CMS will determine whether a revocation is warranted and will notify the contractor via e-mail of its decision.
- Furnishes documentation that the contractor deems adequate, the contractor need not take further action other than to place the documentation and the documentation request letter(s) in the provider file.

5. Additional Guidance Regarding Documentation of Ordering or Certifying

The contractor shall also abide by the following:

- a. When preparing the letter referred to in section 10.6.13(B)(4) above, the contractor shall use the appropriate model language in Section 10.7.17 and 10.7.17 (A) below. Note, however, that while the letters request copies of orders, the contractor has the discretion to ask for different or additional documentation (e.g., documentation that supports the legitimacy of a particular service or the payment of a particular claim). Copies of orders need not be requested in every situation. As alluded to in section 10.6.13(B)(2) above, the contractor would have to examine the facts of each case in determining the type(s) of documentation to be requested.
- b. There may be situations in which CMS directs the contractor to request documentation in a particular case. The contractor shall follow the instructions in this section 10.6.13(B) with respect to doing so.
- c. The contractor shall contact its CMS PEOG BFL if it has questions as to whether particular submitted documentation is adequate or legitimate – specifically, whether it falls within the category of documentation described in section 10.6.12(B)(3) above.

10.6.14 – Application Fees

(Rev. 10524; Issued: 12-17-20; Effective: 11-13-20; Implementation: 11-13-20)

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 (regardless of whether the revalidation application was requested by CMS or voluntarily submitted by the provider or supplier), must submit with their application:

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

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, Form CMS-20134 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. Contractor Activities Upon Receipt

Upon receipt of a paper or Internet-Based PECOS application 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:

1. 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.

2. If the provider:

Has neither paid the fee nor submitted the hardship exception request, the contractor shall send a development letter to the provider notifying it that it has 30 days from the date of the letter to pay the application fee via Pay.gov and any other items that may be missing or needed, and 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.

If the provider or supplier 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 CMS:

i. 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.

ii. 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 continue processing the application as normal.

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

C. Fee 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 current fee amount can be found via PECOS at the following link: <https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do>

Fee amounts for future years will be adjusted by the percentage change in the consumer price index (for all urban consumers) for the 12-month period ending on June 30 of the prior year. CMS will give the contractor and the public advance notice of any change in the fee amount for the coming calendar year.

D. 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:

1. A hardship exception request that is subsequently approved;
2. An application that was rejected prior to the contractor's initiation of the screening process, or
3. An application that is subsequently denied as a result of the imposition of a temporary moratorium under 42 CFR §424.570.

(For purposes of section 10.6.14(C) above, the term "rejected" includes applications that are returned pursuant to section 10.4(H)(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.

E. Format

The provider or supplier must submit the application fee electronically through <https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do>, either via credit card, debit card, or electronic check.

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 section 10.4(C) (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.

Also, with respect to the application fee requirement:

- The fee is based on the Forms CMS-855 and CMS-20134 application submission, not on how enrollment records are created in PECOS. For instance, suppose a hospital submits an initial Form CMS-855A. In the Identifying Information/hospital type section of the application, the hospital indicates that it has a psychiatric unit and a rehabilitation unit. Separate PECOS enrollment records must be created for each unit. However, only one application fee is required because only one Form CMS-855A application was submitted.

- 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.

F. 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 the Practice Location section of the Form CMS-855A.) If multiple locations are being added on a single application, however, only one fee is required. 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.

G. Other Application Submissions

1. Whether/When a Fee is Required: Edit, Change, and Delete an Application

The application fee is not applicable to individual providers and non-institutional providers. For a list of fee requirements broken out by provider/supplier and application type, refer to the Application Fee Matrix at the following link <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/ApplicationFeeRequirementMatrix1.pdf>

2. Change of Ownership Via Form CMS-855B or Form CMS-855S

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

3. Reporting a change in tax identification number

A provider or supplier need not pay an application fee if the application is reporting a change in TIN for a Part A, Part B, or DMEPOS provider or supplier.

4. Requesting a Reactivation

A provider or supplier need not pay an application fee to reactivate Medicare billing privileges unless the provider/supplier was deactivated for failing to respond to a revalidation request, in which case the resubmitted application constitutes a revalidation (not a reactivation) application, hence requiring a fee.

5. Changing the Physical Location of an Existing Practice Location

A provider or supplier need not pay an application fee when changing the physical location of an existing practice location (as opposed to reporting an additional/new practice location).

The application fee requirement is separate and distinct from the site visit requirement and risk categories discussed 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 10.6.15(A)(4) 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.

H. Refund Requests

Unless otherwise approved by CMS, the provider must request a refund no later than 150 days from the date it submitted its application. In its request, the provider shall include documentation acceptable to process the refund request. For credit card refunds, the provider shall include its [Pay.gov](#) receipt or the [Pay.gov](#) tracking ID number; if the fee was paid via ACH Debit, an Authorization and Payment Information Form for EFT for Application Fee Refunds form. The contractor shall collect the application fee refund EFT form when an ACH Debit payment refund is requested.

I. Institutional Provider and Fee: 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. 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.

J. 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 CMS Provider Enrollment & Oversight Group Business Function Lead (PEOG BFL). CMS has 60 calendar days from

the date of the contractor's receipt of the hardship exception request to determine whether it should be approved; during this period, the contractor shall not commence processing the provider's application. CMS will communicate its decision to the provider and the contractor via letter, after which the contractor shall carry out the applicable instructions in section 10.6.14(K) below.

If the provider fails to submit appropriate documentation to support its request, the contractor 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.

K. Appeals of Hardship Determinations

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

1. If the provider is dissatisfied with CMS' decision to deny a hardship exception request, it may file a written reconsideration request with CMS within 60 calendar days from receipt of the notice of initial determination (e.g., CMS' denial letter). The request must be signed by the individual provider or supplier, a legal representative, or any authorized official within the entity. Failure to file a reconsideration request within this timeframe is deemed a waiver of all rights to further administrative review.

The reconsideration request should be mailed to:

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

Notwithstanding the filing of a reconsideration request, the contractor shall still carry out the post-hardship exception request instructions in subsections 10.6.14(K)(2)(a) and (c) above, as applicable. A reconsideration request, in other words, does not stay the execution of the instructions in section 10.6.14(K) above.

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

- a. Conducted by a CMS staff person who was independent from the initial decision to deny the hardship exception request.
- b. Based on CMS' review of the original letter and documentation submitted by the provider.

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

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

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

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

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

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

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

If the ALJ reverses PEOG's reconsideration decision and approves the hardship exception request, 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.

10.6.15 – Risk-Based Screening **(Rev. 10467; Issued: 11-13-20; Effective: 01-01-21; Implementation: 11-01-20)**

A. Risk Based Screening Categories

1. Risk-Based Screening Categories - Background

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

2. Limited Risk Screening Category

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

- Physicians
- Non-physician practitioners other than physical therapists
- Physician group practices
- Non-physician group practices other than physical therapist group practices
- Ambulatory surgical centers
- Competitive Acquisition Program/Part B Vendors
- End-stage renal disease facilities
- Federally qualified health centers
- Histocompatibility laboratories
- Home infusion therapy suppliers
- Hospitals (including critical access hospitals, Department of Veterans Affairs hospitals, and other federally-owned hospital facilities.
- Health programs operated by an Indian Health Program (as defined in section 4(12) of the Indian Health Care Improvement Act) or an urban Indian

organization (as defined in section 4(29) of the Indian Health Care Improvement Act) that receives funding from the Indian Health Service pursuant to Title V of the Indian Health Care Improvement Act

- Mammography screening centers
- Mass immunization roster billers
- Organ procurement organizations
- Outpatient physical therapy/outpatient speech pathology providers enrolling via the Form CMS-855A
- Pharmacies that are newly enrolling or revalidating via the Form CMS-855B application
- Radiation therapy centers
- Religious non-medical health care institutions
- Rural health clinics
- Skilled nursing facilities

For providers and suppliers in the “limited” category, the contractor shall (unless section 10.6.15(A)(1) of this chapter applies) process initial, revalidation, and new location applications in accordance with existing instructions.

3. Moderate Risk Screening Category

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

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

For providers and suppliers in the “moderate” level of categorical screening, the contractor shall (unless section 10.6.15(A)(4) of this chapter or another CMS directive applies):

Process initial, revalidation, and new location applications in accordance with existing instructions; and

Except for revalidating DMEPOS suppliers, order a site visit through the Provider Enrollment, Chain and Ownership System (PECOS) in accordance with sections 2(a) through (e) below. The site visit, which the National Site Visit Contractor (NSVC) will perform, is to ensure that the supplier is in compliance with CMS's enrollment requirements. Unless stated otherwise in this chapter, the scope of the site visit will be consistent with section 10.6.15(A)(4).

a. Ambulance suppliers, independent clinical laboratories, physical therapists, and physical therapist groups

i. Initial application

If the supplier submits an initial application, the contractor shall order a 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.

ii. Revalidation

If the supplier submits a revalidation application, the contractor shall order a 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.

iii. New Location

The contractor shall order a site visit of the location. 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.

b. CMHCs

i. Initial application

In addition to the site visit discussed in section 10.2.1(A)(1)(b) of this chapter, the contractor shall order a site visit after the contractor receives the tie-in notice (or approval letter) from the RO but before the contractor conveys Medicare billing privileges to the CMHC. The contractor shall not convey Medicare billing privileges to the provider prior to the completion of the NSVC's site visit and the contractor's review of the results.

ii. Revalidation

If the CMHC submits a revalidation application, the contractor shall order a 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.

iii. New location

The contractor shall order a site visit of the location after the contractor receives notice of approval from the RO but before the contractor switches the provider's enrollment record to "Approved." The contractor shall not switch the provider's enrollment record to "Approved" prior to the completion of the NSVC's site visit and the contractor's review of the results.

c. CORFs, hospices and PXRSSs

i. Initial application

If the provider/supplier submits an initial application, the contractor shall order a site visit after the contractor receives the tie-in notice (or approval letter) from the RO but before the contractor conveys Medicare billing privileges to the provider/supplier. The contractor shall not convey Medicare billing privileges to the provider/supplier prior to the completion of the NSVC's site visit and the contractor's review of the results.

ii. Revalidation

If the provider/supplier submits a revalidation application, the contractor shall order a 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.

iii. New location

The contractor shall order a site visit of the location after the contractor receives notice of approval from the RO but before the contractor switches the provider/supplier's enrollment record to "Approved." The contractor shall not switch the provider/supplier's enrollment record to "Approved" prior to the completion of the NSVC's site visit and the contractor's review of the results.

d. IDTFs

i. Initial applications

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

ii. Revalidations

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

iii. IDTF Code Changes

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

e. Revalidating HHAs

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

f. Revalidating DMEPOS suppliers

The National Supplier Clearinghouse (NSC) shall conduct a site visit of the DMEPOS supplier prior to making a final decision regarding the revalidation application.

g. Revalidating MDPP Suppliers

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

h. Revalidating OTP Providers

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

4. High Risk Screening Category

a. Newly Enrolling Providers/Suppliers Assigned to the High Risk Screening Category

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

- Newly enrolling DMEPOS suppliers
- Newly enrolling HHAs (including HHAs that must submit an initial enrollment application pursuant to § 424.550(b)(1))
- Newly enrolling MDPP suppliers

- Newly enrolling OTP providers that were SAMSHA certified after October 24, 2018

For providers and suppliers in the “high” level of categorical screening:

- i. The contractor shall process the application in accordance with existing instructions;
- ii. The NSVC will perform a site visit for newly enrolling HHAs. (The NSC will perform a site visit for newly enrolling DMEPOS suppliers.) For initially enrolling HHAs, the contractor shall order a site visit via PECOS after the contractor receives the tie-in notice or approval letter from the RO but before the contractor switches the provider’s enrollment record to “Approved.”
- iii. Newly enrolling HHAs and DMEPOS suppliers are also required to undergo fingerprint-based criminal background checks. The contractor shall not switch the provider’s enrollment record to “Approved” prior to the completion of fingerprinting and the contractor’s review of the results; and
- iv. The contractor shall, upon switching the provider’s or supplier’s enrollment record to “Approved,” enter the provider’s risk category as “moderate” into PECOS.

NOTE:

- Enrolled DMEPOS suppliers that are adding another location will be classified as “high” for screening purposes. (See section 10.6.15(B)(5) below for information regarding DMEPOS changes of ownership and tax identification number (TIN) changes.)
- Newly-enrolling HHA sub-units fall within the “high” level of categorical screening.
- The addition of a new HHA branch falls within the “moderate” level of categorical screening. The contractor shall order a site visit of the location through PECOS after the contractor receives notice of approval from the RO but before the contractor switches the provider’s enrollment record to “Approved.” This is to ensure that the provider is in compliance with CMS’s enrollment requirements. The scope of the site visit will be consistent with section 10.6.15(B)(5) of this chapter. The National Site Visit Contractor (NSVC) will perform the site visit. The contractor shall not switch the provider’s enrollment record to “Approved” prior to the completion of the NSVC’s site visit and the contractor’s review of the results.

This is the only site visit of the new HHA branch that must be performed prior to the record being switched to “Approved.”

- The addition of a new MDPP supplier administrative location that does not result in a new PTAN does not require an additional site visit. Any additional MDPP supplier administrative location that results in a new PTAN, either due to being in a new jurisdiction or because of a new CDC organizational code, the contractors shall order a site visit of the location through PECOS. This is to ensure that the provider 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 switch the provider's enrollment record to "Approved" prior to the completion of the NSVC's site visit and the contractor's review of the results.

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

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

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

CMS makes available to the contractor on a bi-monthly basis a list of current and former Medicare providers and suppliers within the contractor's jurisdiction that meet any of the criteria in subsection (1) or (2) above. Upon receipt of an initial or revalidation application from a provider or supplier that otherwise falls within the limited or moderate screening category (and after the appropriate fee has been paid, etc.), the contractor shall determine whether the provider or supplier is on the bi-monthly "high" screening list. If the provider or supplier is not on said list, the contractor shall process the application in accordance with existing instructions. If the provider or supplier is on the list, the contractor shall process the application using the procedures in the "high" screening category unless the provider is on the list solely because he/she/it was revoked for failing to timely respond to a revalidation request. If such is the case, the contractor shall contact its CMS Provider Enrollment & Oversight Group Business Function Lead (PEOG BFL) for guidance as to how the situation should be handled.

With respect to subsection (3) above, if the contractor receives an initial or new location application from a provider or supplier: (a) that is of a provider or supplier type that was subject to a moratorium and (b) within 6 months after the applicable moratorium was lifted, the contractor shall process the application using the procedures in the "high" screening category.

B. Risk Based Screening: Changes of Information and Ownership

1. Limited

Changes of information (including additions of practice locations) submitted by providers and suppliers in the "limited" level of categorical screening shall be processed in accordance with existing instructions.

2. Moderate and High

Unless otherwise specified in this chapter or in another CMS directive, this section 10.6.15(B)(2) applies to providers and suppliers in the "moderate" or "high" level of categorical screening.

3. Addition of Practice Location

With the exception of suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS), if a provider or supplier submits a Form CMS-855 request to add a practice location (including a home health agency (HHA) branch):

- The contractor shall process the application in accordance with existing instructions, and
- A site visit shall be performed consistent with section 10.6.15(A) above.

(As explained earlier, a DMEPOS supplier that is adding a new practice location falls within the “high” screening category.)

4. Change of Location

a. DMEPOS Suppliers

If a DMEPOS supplier reports a change in the physical location of an existing practice location, the National Supplier Clearinghouse shall perform a site visit.

b. Non-DMEPOS Suppliers

If a provider or non-DMEPOS supplier reports a change in the physical location of an existing practice location, the contractor shall order a site visit through the Provider Enrollment, Chain and Ownership System (PECOS) in accordance with the following:

c. Ambulance service suppliers, independent clinical laboratories, independent diagnostic testing facilities, physical therapists enrolling as individuals or group practices – The contractor shall order a site visit of the changed location prior to the contractor’s final decision regarding the application. This is to ensure that the location is in compliance with CMS’s enrollment requirements. The scope of the site visit will be consistent with section 10.6.15(B) of this chapter. The National Site Visit Contractor (NSVC) will perform the site visit. The contractor shall not make its final decision regarding the application prior to the completion of the NSVC’s site visit and the contractor’s review of the results.

d. Community mental health centers, comprehensive outpatient rehabilitation facilities, hospices, portable x-ray suppliers, HHAs - The contractor shall order a site visit of the changed location after the contractor receives notice of approval from the RO but before the contractor switches the provider/supplier’s enrollment record to “Approved.” This is to ensure that the location is in compliance with CMS’s enrollment requirements. The scope of the site visit will be consistent with section 10.6.15(B) of this chapter. The NSVC will perform the site visit. The contractor shall not switch the provider’s enrollment record to “Approved” prior to the completion of the NSVC’s site visit and the contractor’s review of the results.

For purposes of this requirement:

- A change of location includes situations in which the provider/supplier is switching suite numbers or floors within a building. A site visit is required.
- If the provider/supplier’s physical location is not changing (e.g., the provider’s street name is changing but its actual office space is not), no site visit is required.

5. Change of Ownership

With the exception of DMEPOS suppliers and HHAs, if a provider or supplier undergoes a change of ownership resulting in a new tax identification number (TIN), the contractor shall:

- a. Process the application in accordance with existing instructions, and
- b. Order a site visit through PECOS in accordance with the following:
 - For ownership changes that must be approved by the RO under current CMS instructions, the site visit shall be ordered and performed after the contractor receives notice of approval from the RO but before the contractor switches the provider/supplier's enrollment record to an "Approved" status. The contractor shall not switch the provider/supplier's enrollment record to "Approved" prior to the completion of the NSVC's site visit and the contractor's review of the results.
 - For ownership changes that do not require RO approval under current CMS instructions, the site visit shall be ordered and performed prior to the contractor's final decision regarding the application.
 - A DMEPOS supplier that is:
 - Undergoing a change of ownership with a change in TIN falls within the "high" screening category.
 - Undergoing a change of ownership with no change in TIN falls within the "moderate" screening category.
 - Undergoing a change in TIN with no change in ownership falls within the "moderate screening category.

With respect to HHAs:

- For HHAs undergoing a change in majority ownership, the contractor shall – consistent with section 10.2.1(F)(8) of this chapter – determine whether the provisions of 42 CFR §424.550(b)(1) and (2) apply. If the contractor determines that a change in majority ownership has occurred and that none of the exceptions in §424.550(b)(2) apply, the HHA must enroll as a new entity, in which case the newly-enrolling HHA will be placed into the "high" level of categorical screening. If the contractor determines that an exception does apply, the transaction will be subject to the "moderate" level of categorical screening; a site visit will be necessary.
- In addition, if: (1) the contractor determines that one of the exceptions to the 36-month rule applies, and (2) the ownership change is one that requires a recommendation for approval to the RO, the contractor shall ensure that its recommendation letter specifies:

- That the transaction qualifies as a change in majority ownership
- The particular exception that applies.
- For HHAs reporting an ownership change that is not a change in majority ownership as that term is defined in §424.502, the contractor shall process the change in accordance with existing instructions. A site visit is not necessary.
- For HHAs seeking to reactivate their Medicare billing privileges, the transaction shall be processed under the “moderate” level of categorical screening. A site visit will be necessary prior to the reactivation of the provider’s billing privileges.

6. All Other Changes of Information

All other changes of information for providers and suppliers in the moderate or high level of categorical screening shall be processed in accordance with existing instructions.

C. Risk Based Screening – Reactivations

1. Form CMS-855 Reactivations

a. Limited

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

b. Moderate

Form CMS-855 reactivation applications submitted by providers and suppliers in the “moderate” level of categorical screening – including existing 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.

c. High

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

10.6.16 – Temporary Moratoria

(Rev. 10524; Issued: 12-17-20; Effective: 11-13-20; Implementation: 11-13-20)

Under §424.570(a), CMS may impose a moratorium on the enrollment of new Medicare providers and suppliers of a particular type or the establishment of new practice locations of a particular type in a particular geographic area. The announcement of a moratorium will be made via the Federal Register, though the contractor will be separately notified of the moratorium.

The contractor shall abide by all CMS directives and instructions issued pursuant to the imposition or lifting of a particular moratorium.

10.6.17 – Deceased Practitioners

(Rev. 10524; Issued: 12-17-20; Effective: 11-13-20; Implementation: 11-13-20)

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

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

B. Erroneous Report of Death

In the event of an erroneous report of death the contractor shall reach out the CMS PEOG BFL for guidance.

C. Verification Activities for Individuals Other than Physicians, Non-Physician Practitioners and/or Suppliers of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)

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

Once the contractor verifies the report of death, it shall notify the provider or supplier organization with which the individual is associated that it needs to submit a Form CMS-855 change request that deletes the individual from the provider or supplier's enrollment record. If the provider fails to submit this information within 90 calendar days of the contractor's request, the contractor shall deactivate the provider's Medicare billing privileges in accordance with 42 CFR §424.540(a)(2). (DMEPOS Suppliers Only -If a DMEPOS supplier fails to submit this information within 30 calendar days of the contractor's request, the contractor shall deactivate the supplier's billing privileges in accordance with 42 CFR §424.57(c)(2).)

The contractor need not, however, solicit a Form CMS-855 change request if the organization is enrolled with another contractor. Here, the contractor shall notify (via fax or e-mail) the contractor with which the organization is enrolled of the situation, at which time the latter contractor shall take actions consistent with this section 10.6.17.

D. Reports of Death from Third-Parties

1. Verification of Death

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

- Obtaining oral or written confirmation of the death from an authorized or delegated official of the group practice to which the physician, non-physician practitioner or DMEPOS supplier had reassigned his or her benefits;
- Obtaining an obituary notice from the newspaper;
- Obtaining oral or written confirmation from the state licensing board (e.g., telephone, e-mail, computer screen printout);
- Obtaining oral or written confirmation from the State Bureau of Vital Statistics; or
- Obtaining a death certificate, Form SSA-704, or Form SSA-721 (Statement of Funeral Director).

2. Deceased Individuals: Post-Confirmation Actions

Once the contractor verifies the death, it shall:

- a. Undertake all actions normally associated with the deactivation of a supplier's billing privileges.
- b. Search PECOS to determine whether the individual is listed therein as an owner, managing employee, director, officer, partner, authorized official, or delegated official of another supplier.
- c. If the person is not in PECOS, no further action with respect to that individual is needed.
- d. If the supplier is indeed identified in PECOS as an owner, sole owner of his/hers professional corporation or professional association, officer, etc., the contractor shall notify the organization with which the person is associated that it needs to submit a Form CMS-855 change request that deletes the individual from the entity's enrollment record. If a provider fails to submit this information within 90 calendar

days of the contractor's request, the contractor shall deactivate the provider's billing privileges in accordance with §424.540(a)(2). (DMEPOS Suppliers Only - If a DMEPOS supplier fails to submit this information within 30 calendar days of the contractor's request, the contractor shall deactivate the supplier's billing privileges in accordance with §424.57(c)(2).)

The contractor need not, however, ask for a Form CMS-855 change request if the organization is enrolled with another contractor. In this situation, the contractor shall notify (via fax or e-mail) the contractor with which the organization is enrolled of the situation, at which time the latter contractor shall take actions consistent with this section 10.6.17.

The contractor shall place verification documentation in the provider or supplier file in accordance with section 10.6.19(H) of this chapter.

E. Deceased Individuals: Education & Outreach

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

F. Process to Deactivate NPI Due to a Death

1. Trustees/Legal Representatives

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

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

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

- Form CMS-855 change of information request that updates the "Special Payment" address in the application. The Form CMS-855 can be signed by the trustee/legal representative.
- Any evidence – within reason - verifying that the physician, non-physician practitioner or DMEPOS supplier is in fact deceased.

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

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

G. Other Enrollment Information

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

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

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

- a. The practice's billing privileges have been deactivated;
- b. Any services furnished by him/her on behalf of the practice after the date of the owning physician/practitioner's death or date of revocation or deactivation will not be paid; and
- c. If the employed physician/practitioner wishes to provide services at the former practice's location, he/she must submit via Internet-based PECOS (or a paper Form CMS-855 application) a Form CMS-855I change of information request to add the owning physician/practitioner's practice location as a new location of the employed physician/practitioner. For purposes of this section 10.6.17(G)(1)(c) only, submission of a (1) complete Form CMS-855I application as an initial enrollment and (2) a terminating Form CMS-855R application are not required – even if the employed physician/non-physician practitioner had reassigned all of his/her benefits to the practice.

H. Proof of Life Documentation

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

10.6.18 – Appeals Process

(Rev. 10735; 04-27- 21; Effective: 05-27-21; Implementation: 05-27-21)

A. Review Procedures for Determinations that Affect Participation in the Medicare Program

1. Background

This review process of initial determinations applies to all providers and suppliers and ensures that all current and prospective providers and suppliers receive a fair and full opportunity to be heard. With the implementation of the appeals provision of Section 936 of the Medicare Prescription Drug Modernization and Improvement Act (MMA), all providers and suppliers that wish to appeal will be given the opportunity to request Administrative Law Judge (ALJ) review of a reconsideration decision within the Civil Remedies Division of the Departmental Appeals Board (CRD DAB). Providers and suppliers may thereafter seek review of the ALJ decision in the Appellate Division of the Departmental Appeals Board (DAB) and may then request judicial review in Federal District Court.

For purposes of this chapter, in accordance with 42 C.F.R. § 498.3, an initial determination includes: (1) the denial of enrollment in the Medicare program; (2) the revocation of a provider’s or supplier’s Medicare billing privileges; and (3) the effective date of participation in the Medicare program.

Any corrective action plan (CAP) or reconsideration request that purports to challenge an enrollment action other than the initial determinations identified above (including inclusion on the CMS Preclusion List and Opt-Out Status) shall be forwarded to CMS at ProviderEnrollmentAppeals@cms.hhs.gov for review within 10 business days of the date of receipt. The Medicare Administrative Contractor (MAC) shall take no action on the provider’s or supplier’s information on its enrollment record regarding an appeal submission for revocations forwarded to CMS for processing unless otherwise

instructed by the Provider Enrollment and Oversight Group (PEOG).

A provider or supplier dissatisfied with the initial determinations referenced above, may challenge the determination. All properly submitted requests shall be reviewed at the enrollment level. As a result, if one letter attempts to challenge the initial determination for a group enrollment in addition to individual practitioner enrollment(s), each enrollment shall receive a separate decision. All submissions shall be processed in the order in which they are received. All CAPs and/or reconsideration requests will be reviewed by an individual separate and apart from the individual involved in the implementation of the initial determination.

Depending on the regulatory authority under which an initial determination is issued, providers and suppliers may be entitled to submit a CAP and/or a reconsideration request. A CAP is a plan that allows a provider or supplier an opportunity to demonstrate compliance with all applicable Medicare requirements by correcting the deficiencies (if possible) that led to the initial determination, specifically either the denial of enrollment into the Medicare program under 42 C.F.R. § 424.530(a)(1) or the revocation of Medicare billing privileges pursuant to 42 C.F.R. § 424.535(a)(1). While CAPs may only be submitted in response to a denial under 42 C.F.R. § 424.530(a)(1) or a revocation under 42 C.F.R. § 424.535(a)(1), all initial determinations allow for the submission of a reconsideration request. A reconsideration request allows the provider or supplier an opportunity to demonstrate that an error was made in the initial determination at the time the initial determination was implemented. In contrast to a CAP, a reconsideration request does not allow a provider or supplier the opportunity to correct the deficiencies that led to the initial determination.

Any CAPs and/or reconsideration requests received in response to initial determinations involving the following, either in whole or in part, shall be forwarded to CMS for review within 10 business days of the date of receipt. The CAP and/or reconsideration request shall be sent to the PEOG Provider Enrollment Appeals inbox at ProviderEnrollmentAppeals@cms.hhs.gov.

- All CAPs and reconsideration requests for certified providers/suppliers (as defined in Sections 10.2.1 and 10.2.2 of this chapter) and institutional providers/suppliers which have been revoked (as defined in Section 10.4(M)(2)(e) of this chapter);
- CAPs and reconsideration requests for Independent Diagnostic Testing Facilities;
- CAPs and reconsideration requests for Medicare Diabetes Prevention Programs (MDPP);
- CAPs and reconsideration requests for Opioid Therapy Programs (OTPs);

- Reconsideration requests for enrollment denials pursuant, in whole or in part, to 42 C.F.R. § 424.530(a)(2), (3), (6), (11), (12), (13), and (14);
- Reconsideration requests for revocations pursuant, in whole or in part, to 42 C.F.R. § 424.535(a)(2), (3), (4), (7), (8), (10), (12), (13), (14), (17), (18), (19), (20), (21) and (22);
- Requests for reversals of denials pursuant to 42 C.F.R. § 424.530(c) and/or revocations pursuant to 42 C.F.R. § 424.535(e);
- Reconsideration requests for revocations pursuant, in whole or in part, to 42 C.F.R. § 424.535(j);
- Reconsideration requests challenging the addition of years to an existing re-enrollment bar;
- Reconsideration requests challenging whether an individual or entity other than the provider or supplier that is the subject of the second revocation was the actual subject of the first revocation;
- Reconsideration requests challenging an individual or entity being included on the CMS Preclusion List as defined in § 422.2 or § 423.100; and
- Reconsideration requests regarding opt-out status.

If the provider or supplier is denied enrollment or has its Medicare billing privileges revoked, under 42 C.F.R. § 424.530(a)(1) or 42 C.F.R. § 424.535(a)(1), (5) or (9), in conjunction with any denial or revocation reason(s) listed above, those CAPs and/or reconsideration requests should also be forwarded to CMS at ProviderEnrollmentAppeals@cms.hhs.gov for review within 10 business days of the date of receipt and the determination will be rendered by CMS. If the provider or supplier only submits a CAP for the noncompliance portion of any initial determinations listed above, the CAP must be sent to CMS at ProviderEnrollmentAppeals@cms.hhs.gov for review within 10 business days of the date of receipt, even if the provider or supplier does not submit a reconsideration request. The MAC shall not process the CAP if it is required to be forwarded to CMS. If the provider or supplier later submits a reconsideration request, the reconsideration request must also be sent to CMS at ProviderEnrollmentAppeals@cms.hhs.gov within 10 business days of the date of receipt.

All CAPs and reconsideration requests received by the MACs that are not specifically identified above as being required to be forwarded to CMS for review, shall be processed and a decision rendered by the MACs. However, CMS may exercise its discretion to review any CAP and/or reconsideration request and issue a decision

regardless of the basis for the initial determination.

(NOTE: This includes all CAPs and reconsideration requests for DMEPOS suppliers that fit the criteria identified above. In addition, as also indicated above, CAPs may only be submitted for denials pursuant to 42 C.F.R. § 424.530(a)(1) and revocations pursuant to 42 C.F.R. § 424.535(a)(1). However, in the event a CAP is submitted for revocations pursuant, in whole or in part, to 42 C.F.R. § 424.535(a)(2), (3), (4), (7), (8), (10), (12), (13), (14), (17), (18), (19), (20), (21), or (22) the submission should still be forwarded to CMS within 10 business days of the date of receipt to the PEOG Provider Enrollment Appeals inbox at ProviderEnrollmentAppeals@cms.hhs.gov.)

PEOG shall notify the MAC via email when it receives a CAP and/or reconsideration request for a provider or supplier that has not been previously forwarded to PEOG by the MAC. The MAC shall not take any action on a provider or supplier's information on its enrollment record if there is a CAP and/or reconsideration request pending for a revocation action unless otherwise instructed by PEOG. The MAC shall email ProviderEnrollmentAppeals@cms.hhs.gov with any inquiries, questions, or requests.

All documentation related to CAPs and reconsideration requests (including, but not limited to, the decisions) shall be saved in PDF format. The date on the CAP and reconsideration request decisions should be the same date as the date the decision is issued to the provider/supplier/representative.

2. Reopening and Revising CAP and Reconsideration Determinations

Once a CAP and/or reconsideration decision is issued, the MAC shall not reopen and revise a CAP and/or reconsideration decision without PEOG's prior approval, even if the MAC rendered the CAP or reconsideration decision independently. The MAC shall send all requests to reopen and revise a CAP and/or reconsideration decision to ProviderEnrollmentAppeals@cms.hhs.gov and await further instruction before taking any action regarding the CAP and/or reconsideration decision.

3. Requests to the MACs

The MAC shall work with and provide PEOG and the Office of General Counsel (OGC), when applicable, all necessary documentation related to any and all CAPs, reconsideration requests, ALJ appeals, DAB appeals, or requests for judicial review.

The following are examples of information the MAC may be asked to provide. This is not an exhaustive list.

- A copy of the initial determination letter;
- A chronological timeline outlining: (1) the processing of applications; (2) the date they began providing services at the newest assigned location; and (3) if there were development requests;

- The hearing officer's decision as well as the provider or supplier's CAP and/or reconsideration request;
- A complete copy of all application Form CMS-855s, and any supporting documentation submitted with the provider or supplier's application;
- All background information and investigative data the hearing officer used to make their decision. Including any on-site visit reports; the MAC's recommendation for administrative action based on the on-site visit;
- Contact information for the person(s) who signed both the revocation and reconsideration decision letters.

The MAC shall supply PEOG or OGC with all requested documentation within 5 business days of receipt of the request, unless requested sooner.

All requested documentation shall be provided in PDF format (if possible) and saved with a file name that identifies the content of the document.

If a CAP and/or reconsideration decision requires the MAC to take action on a provider's or supplier's enrollment, such as reinstating the provider's or supplier's enrollment to an active status, the MAC shall complete all updates to the provider's or supplier's enrollment within 10 business days of the date the CAP and/or reconsideration decision is issued unless additional documentation is needed to update the enrollment. If a CAP or reconsideration decision requires the provider or supplier to submit further information before the enrollment can be updated, such as an enrollment application, the MAC shall allow 30 calendar days for the provider or supplier to submit the necessary information. The MAC shall complete all updates to the provider's or supplier's enrollment within 10 business days of the date of receipt of the additional information/documentation. If the provider or supplier does not submit the necessary information within 30 calendar days, the MAC shall contact PEOG by emailing ProviderEnrollmentAppeals@cms.hhs.gov for further instruction.

4. Timing of CAP and Reconsideration Request Submissions

A provider or supplier who wishes to submit a CAP must file its request in writing within 35 calendar days of the date of the initial determination. A provider or supplier who wishes to submit a reconsideration request must file its request in writing within 65 calendar days of the date of the initial determination. The date on which CMS or the MAC receives the submission is considered to be the date of filing. See section D below for information on calculating timely submissions.

The mailing and email address for all CAPs and reconsideration requests to be rendered by CMS identified in section 10.6.18(A) is:

Centers for Medicare & Medicaid Services
Provider Enrollment & Oversight Group
Attn: Division of Compliance and Appeals
7500 Security Boulevard
Mailstop AR-18-50
Baltimore, MD 21244-1850

Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review, and may result in the dismissal of any untimely submitted reconsideration request. 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 circumstances outside of the provider's or supplier's control such as 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.

If a reconsideration request is not timely filed, as required in 42 C.F.R. § 498.22, CMS will make a determination as to whether good cause exists. If a MAC receives an untimely CAP and/or reconsideration request that it believes is entitled to a good cause exception related to untimeliness, the hearing officer must request approval from PEOG by emailing ProviderEnrollmentAppeals@cms.hhs.gov with an explanation as to why good cause is believed to exist before making a finding of good cause or taking any other action regarding the CAP and/or reconsideration request. The MAC shall not take action on the CAP and/or reconsideration request until it receives a response from CMS regarding the good cause exception request.

5. Time Calculations

Per 42 C.F.R. § 498.22(b)(3), the date of receipt of an initial determination is presumed to be 5 calendar days after the date on the initial determination notice unless there is a showing that it was, in fact, received earlier or later.

A CAP must be received by the MAC or CMS within 35 calendar days of the date of the initial determination. A reconsideration request must be received by the MAC or CMS within 65 calendar days of the date of the initial determination. If the 35th day (for a CAP) or 65th day (for a reconsideration request), falls on a weekend, or Federally recognized holiday, the CAP and/or reconsideration request shall be considered timely filed if received on the next business day. In the case of an email submission of a CAP and/or reconsideration request, the filing date is presumed to be the date of receipt of the email. Consider the following example:

An initial determination letter is dated April 1. The provider is presumed to have received the initial determination on April 6. The provider submits a CAP and/or reconsideration request by mail that is received on June 10, 65 calendar days after April 6. This is considered timely because it is presumed that the provider did not receive the initial determination letter until April 6.

It is the provider or supplier's responsibility to timely update its enrollment record to reflect any changes to the provider or supplier's enrollment information, including its correspondence address. Failure to timely update a correspondence address or other address included in the enrollment record does not constitute an "in fact" showing that an initial determination letter was received after the presumed date of receipt.

6. Signatures

A CAP and/or reconsideration request must be submitted in the form of a letter that is signed by the individual provider, supplier, the authorized or delegated official, or a properly appointed representative, as defined in 42 C.F.R. § 498.10. If the representative is an attorney, the attorney must include a statement that he or she has the authority to represent the provider or supplier. This statement is sufficient to constitute notice. If the representative is not an attorney, the provider or supplier must file written notice of the appointment of a representative with the contractor. This notice of appointment must be signed by the individual provider or supplier, or the authorized or delegated official. The signature need not be original and can be electronic.

Authorized or delegated officials for groups cannot sign and submit a CAP and/or reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her behalf.

(NOTE: The provider or supplier's contact person (as listed in section 13 of the Form CMS- 855) does not qualify as a "representative" for purposes of signing a reconsideration request without the requisite appointment statement and signature by the individual provider or supplier.)

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

If the CAP and/or reconsideration request submission is not appropriately signed and no response is timely received to the development request (if applicable), the MAC shall dismiss the CAP and/or reconsideration request using the applicable model

dismissal letter.

7. Representative for CAP and/or Reconsideration Request

Per 42 C.F.R. § 498.10, a provider or supplier may appoint as its representative any individual that is not disqualified or suspended from acting as a representative in proceedings before the Secretary of the Department of Health and Human Services or otherwise prohibited by law to engage in the appeals process. If this individual is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative. If the representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with CMS or the MAC. Once a representative has been properly appointed, the representative may sign and/or submit a CAP, reconsideration request, request for reversal, or a request for good cause exception on behalf of the provider or supplier.

8. Submission of Enrollment Application while a CAP and/or Reconsideration Request is Pending/Submission Timeframe has not Expired

If a provider or supplier's enrollment application is denied, the provider or supplier must wait until the time period in which to submit a CAP and/or reconsideration request has ended before submitting a new enrollment application, change of information, or provides any additional information to update their enrollment record. If the MAC receives an enrollment application, change of information, or additional information to update a provider's or supplier's enrollment record prior to the conclusion of the time period in which to submit a CAP and/or reconsideration request, the MAC shall return the application unless the application is received as part of the provider's or supplier's CAP and/or reconsideration request submission. The MAC shall not modify the enrollment record of a provider or supplier that currently has a pending CAP and/or reconsideration request for revocations or is still within the submission time period for denials unless instructed by CMS to do so. Any applications received while the provider or supplier is in a revoked status should be returned to the provider or supplier and not processed pursuant to Section 10.4(H)(1).

B. Corrective Action Plans (CAPs)

1. Background

A CAP is a plan that allows a provider or supplier an opportunity to demonstrate compliance by correcting the deficiencies (if possible) that led to the initial determination. CAPs may only be submitted in response to enrollment denials pursuant to 42 C.F.R. § 424.530(a)(1) and revocation of Medicare billing privileges pursuant to 42 C.F.R. § 424.535(a)(1).

2. Requirements for CAP Submission

CAP submission:

(a) Must contain, at a minimum, verifiable evidence that the provider or supplier is in compliance with all applicable Medicare requirements;

(b) Must be received within 35 calendar days from the date of the initial determination (see section 10.6.18(A)(4) for clarification on timing). The contractor shall accept a CAP via hard-copy mail, email, and/or fax;

(c) Must be submitted in the form of a letter that is signed by the individual provider or supplier, the authorized or delegated official that has been reported within your Medicare enrollment record, or a properly appointed representative;

(d) Should include all documentation and information the provider or supplier would like to be considered in reviewing the CAP.

(e) For denials, the denial must be based on 42 C.F.R. § 424.530(a)(1);

i. For denials based on multiple grounds of which one is § 424.530(a)(1), the CAP may only be accepted with respect to § 424.530(a)(1), but not with respect to the other grounds. If the provider or supplier submits a CAP that does not comply with this paragraph, the MAC shall address this in the acknowledgement email or letter sent to the provider or supplier using the model acknowledgement letter (If multiple grounds are involved of which one is § 424.530(a)(1), the MAC shall:

A. Only consider the portion of the CAP pertaining to § 424.530(a)(1). The other denial bases may only be reviewed as a reconsideration.

(f) For revocations, the revocation must be based on 42 C.F.R. § 424.535(a)(1);

i. Consistent with § 405.809, CAPs for revocations based on grounds other than § 424.535(a)(1) shall not be accepted.

A. For revocations based on multiple grounds of which one is § 424.535(a)(1), the CAP may be accepted with respect to 424.535(a)(1), but not with respect to the other grounds. If the provider or supplier submits a CAP that does not comply with this paragraph, the MAC shall address this in the acknowledgment email or letter sent to the provider or supplier using the model acknowledgment letter. (If multiple grounds are involved of which one is § 424.535(a)(1), the MAC shall:

1. Only consider the portion of the CAP pertaining to § 424.535(a)(1). The other revocation bases may only be reviewed as a reconsideration.

3. Receipt Acknowledgment of CAP

If the MAC receives an acceptable CAP for a provider or supplier, the MAC shall use the model acknowledgment letter to email (if a valid email address is available) and send a hard-copy letter to the address included on the CAP submission letter or if no address is listed on the CAP submission letter, then the return address on the envelope from which the CAP was submitted within 14 calendar days of the date of receipt of the CAP, informing the provider, supplier, or its representative that a CAP decision will be rendered within 60 calendar days of the date of receipt of the CAP. If no address is listed in the CAP, then an acknowledgment letter should be sent to the correspondence address on the provider's or supplier's enrollment record.

If the provider's or supplier's CAP cannot be accepted due to untimeliness, an improper signature (including a failure to respond to development for the required statement or signed declaration from a representative), or any other reason, the MAC shall **not** send the provider or supplier an acknowledgment email or letter. Instead, the MAC shall dismiss the CAP using the applicable model dismissal letter.

4. Dismissing a CAP

A CAP shall be dismissed when the provider or supplier does not have the right to submit a CAP for the initial determination, or when the provider or supplier submitted the CAP improperly or untimely (see Section 10.6.18(B)(2)). As a result, the CAP shall not be reviewed. The MAC shall use the model dismissal letter when dismissing a CAP. All unacceptable CAPs shall be dismissed as soon as possible.

If a provider or supplier concurrently submits a CAP and reconsideration request, but the initial determination being appealed does not afford CAP rights or the CAP submission is untimely, the MAC shall dismiss the CAP using the No CAP Rights Dismissal Model Letter or Untimely CAP Dismissal Model Letter and review the reconsideration request in accordance with the instruction in Section 10.6.18(C).

5. CAP Analysis

The MAC shall only review the CAP as it relates to denial of enrollment pursuant to 42 C.F.R. § 424.530(a)(1) or a revocation of billing privileges pursuant to § 424.535(a)(1). The MAC must determine whether or not the information and documentation submitted with the CAP establishes that the provider or supplier has demonstrated compliance with all applicable Medicare rules and requirements by correcting the deficiency that led to the initial determination. If the MAC finds that the CAP corrects the deficiency that led to the initial determination, then the MAC shall overturn the initial determination as it relates to the denial reasons under 42 C.F.R. § 424.530(a)(1) or revocation under 42 C.F.R. § 424.535(a)(1). If the denial of enrollment is overturned completely, the MAC shall continue processing the previously denied enrollment

application in accordance with standard processing procedures. If the revocation is overturned completely, the MAC shall reinstate the provider's or supplier's enrollment to an approved status based on the date the provider or supplier came into compliance. Consider the following example:

Example 1: A provider or supplier is denied enrollment under 42 C.F.R. § 424.530(a)(1) or revoked under 42 C.F.R. § 424.535(a)(1) because its required license has been suspended. The provider timely submits a CAP in which it provides evidence that its licensure has been reinstated and is currently active. After confirming the status of current licensure, the MAC should render a favorable CAP decision because the provider or supplier has corrected the licensure issue that led to enrollment denial or revocation.

If the provider or supplier submitted a CAP for reasons in addition to 42 C.F.R. § 424.535(a)(1), the MAC shall include in the decision letter that the CAP was reviewed only in regards to the 42 C.F.R. § 424.535(a)(1) basis.

If the provider or supplier does not submit information that establishes compliance with all applicable Medicare rules and requirements by correcting the deficiency that led to the initial determination, the MAC need not contact the provider or supplier for the missing information or documentation. The MAC shall instead deny the CAP. Under 42 C.F.R. § 405.809(a)(2), with respect to the revocation basis, the supplier has only one opportunity to correct all deficiencies that served as the basis of its revocation through a CAP.

6. Processing and Approval of CAPs

The time to submit a reconsideration request continues to run even though the MAC has received a CAP and is reviewing the CAP. Therefore, the time period in which to submit a reconsideration request does not stop once a CAP is received and while the CAP is being reviewed. The provider or supplier must submit a reconsideration request within 65 days of the date of the initial determination, even if a CAP is timely submitted and accepted.

The hearing officer shall issue a written decision within 60 calendar days of the date of receipt of the accepted CAP. The hearing officer shall email and mail a hard copy of the CAP decision to the provider or supplier or the individual that submitted the CAP, unless an email address is unavailable or the email is returned, then only a hard copy letter shall be mailed to the return address on the reconsideration request/envelope or the mailing address on the provider's/supplier's enrollment record if no return address is included on the reconsideration request. The MAC should also send the CAP decision letter via fax if a valid fax number is available.

If the MAC approves a CAP, it shall notify the provider or supplier by issuing a favorable decision letter following the applicable model CAP letter. The MAC shall continue processing the enrollment application under standard processing timelines or restore billing privileges (as applicable) within 10 business days of the date of the CAP decision or the date of receipt of additional documentation, if needed.

For denials – and unless stated otherwise in another CMS directive or instruction – the effective date is the later of either the date of the filing of the enrollment application or the date on which services were first rendered. Consider the following examples:

a. Denials

A physician's initial enrollment application is denied on March 1, 2018. The physician submits a CAP showing that, as of March 20th, the physician was in compliance with all Medicare requirements. If the MAC or CMS approves the CAP, the effective date of for the physician's Medicare billing privileges should be March 20th, as that is the day on which the physician came into compliance with all Medicare requirements. The 30-day retrospective billing provision should not be applied in this situation because the rule assumes that the provider was in compliance with Medicare requirements during the 30-day period. This was not the case here. The physician was not in compliance with all Medicare requirements until March 20.

b. Revocations

A physician's medical license is suspended on June 1st. The physician's Medicare enrollment is revoked under 42 C.F.R. § 424.535(a)(1) on June 15th. The physician then submits a CAP showing that, as of July 1st, the physician is currently licensed. If the MAC or CMS approves the CAP, the effective date for reactivation of the physician's Medicare billing privileges should be July 1st as that is the day on which physician came into compliance with all Medicare requirements. The 30-day retrospective billing provision does not be apply in this situation.

The MAC shall ensure that the applicable CMS Regional Office is notified of the outcome of any CAP decision that involves the revocation of Medicare billing privileges for a certified provider or supplier.

If additional information/documentation is needed prior to reinstating the provider or supplier, the MAC shall document these next steps in their CAP decision letter. The MAC shall not reinstate the provider's or supplier's enrollment until the requested information is received and processed. If the additional information/documentation is not received within 30 calendar days of the date of the CAP decision letter, the MAC shall contact the provider or supplier via the applicable model letter to again request the additional information/documentation within 10 calendar days of not receiving a response. If no response is received within 30 calendar days of the second request for additional information/documentation, the MAC shall contact ProviderEnrollmentAppeals@cms.hhs.gov within 10 calendar days for further instruction.

7. Withdrawal of CAP

The provider, supplier, or the individual who submitted the CAP may withdraw the CAP at any time prior to the mailing of the CAP determination. The withdrawal of the

CAP must be postmarked prior to the CAP determination date. The request to withdraw the CAP must be made in writing, signed, and filed with the MAC or CMS. If the MAC receives a request to withdraw a CAP, it shall send a letter or e-mail to the provider or supplier acknowledging receipt of the request to withdraw the CAP and advising that the request has been dismissed, utilizing the applicable model letter.

8. Concurrent Submission of CAP and Reconsideration Request

If a provider or supplier submits a CAP and a reconsideration request concurrently in response to any denial of enrollment under 42 C.F.R. § 424.530(a)(1) or any revocation of billing privileges under 42 C.F.R. § 424.535(a)(1), the MAC shall first process and make a determination regarding the CAP, only as it relates to the denial and/or revocation under 42

C.F.R. § 424.530(a)(1) or 42 C.F.R. § 424.535(a)(1). If the MAC renders a favorable decision as it relates to 42 C.F.R. § 424.530(a)(1) or 42 C.F.R. § 424.535(a)(1), the MAC shall only render a reconsideration decision on the remaining authorities not addressed by the favorable CAP decision. Processing timelines still apply.

If a CAP and a reconsideration request (see Section 10.6.18(B)(8) below) are submitted concurrently, the MAC shall coordinate the review of the CAP and reconsideration request to ensure that the CAP is reviewed and a decision rendered before a reconsideration decision is rendered (if the initial determination is not resolved in its entirety by the CAP decision).

If the CAP is approved and resolves the basis for the initial determination in its entirety, the model CAP decision letter shall be sent to the provider or supplier with a statement that the reconsideration request will not be evaluated because the initial determination has been overturned. If the CAP decision does not fully resolve the initial determination or results in a gap in the provider's or supplier's billing privileges, the MAC shall also process the reconsideration request.

If the CAP is denied:

- There are no further appeal rights; therefore, the CAP decision cannot be appealed. As a result, do not include further appeal rights for a CAP only decision.
- The MAC shall notify the provider or supplier of the denial of the CAP via the applicable CAP model letter.
- The provider or supplier may continue with the appeals process if it has filed a reconsideration request or is preparing to submit such a request and has not exceeded the timeframe in which to do so.
- The reconsideration request, if properly submitted, shall be processed.

C. Reconsideration Requests

1. Background

A reconsideration request allows the provider or supplier an opportunity to demonstrate that an error was made in the initial determination at the time the initial determination was implemented. In contrast to a CAP, a reconsideration request does not allow a provider or supplier the opportunity to correct the deficiencies that led to the initial determination.

2. Requirements for Reconsideration Request Submission

- a. Must contain, at a minimum, state the issues, or the findings of fact with which the affected party disagrees, and the reasons for disagreement;
- b. Must be received within 65 calendar days from the date of the initial determination (see Section 10.6.19(A)(4) for clarification on timing). The contractor shall accept a reconsideration request via hard-copy mail, email, and/or fax;
- c. Must be submitted in the form of a letter that is signed by the individual provider or supplier, the authorized or delegated official that has been reported within your Medicare enrollment record, or a properly appointed representative;
- d. Should include all documentation and information the provider or supplier would like to be considered in reviewing the reconsideration request;

3. Receipt Acknowledgement of Reconsideration Request

Upon receipt of a properly submitted reconsideration request, the MAC shall send an email (if a valid email address is available) and hard-copy letter, to the individual that submitted the reconsideration request to acknowledge receipt of the reconsideration request using the applicable model acknowledgment letter within 14 calendar days of the date of receipt of the reconsideration request. The MAC shall send a hard-copy letter to the address listed in the reconsideration request submission or the return address listed on the reconsideration request submission envelope if no address is included on the reconsideration request letter. If no address is listed in the reconsideration request or on the envelope, then an acknowledgment letter should be sent to the correspondence address on the provider's or supplier's enrollment record. In the acknowledgment letter/email (if applicable), the MAC shall advise the requesting party that the reconsideration request will be reviewed and a determination will be issued within 90 calendar days from the date of receipt of the reconsideration request. The MAC shall include a copy of the acknowledgment letter and email (if applicable) in the reconsideration file. If the reconsideration should have been submitted to CMS, the MAC shall not send the provider or supplier an acknowledgment email or letter. Instead, the MAC shall forward the appeal to CMS within 10 business days of the date of receipt of the reconsideration request (as specified in Section 10.6.18(A)(1)).

If the provider's or supplier's reconsideration request cannot be accepted due to

untimeliness, an improper signature (including a failure to respond to development for the required statement or signed declaration from a representative, or any other reason), the MAC shall not send the provider or supplier an acknowledgment email or letter. Instead, the MAC shall dismiss the reconsideration request using the applicable model dismissal letter.

4. Reconsideration Determination

The MAC shall review all documentation in the record relevant to the initial determination and issue a written determination within 90 calendar days of the date of receipt of the accepted reconsideration request.

A proper reconsideration request must be received by the MAC or CMS within 65 calendar days of the date of the initial determination. Refer to Section 10.6.18(A)(4) for receipt date determinations. However, consistent with 42 C.F.R. § 498.24(a), the provider or supplier, may submit corrected, new, or previously omitted documentation or other facts in support of its reconsideration request at any time prior to the reconsideration decision being issued. The hearing officer must determine whether an error was made in the initial determination at the time the initial determination was implemented, 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.

If the appealing party has additional information that it would like the hearing officer to consider during the reconsideration or, if necessary, an administrative law judge (ALJ) to consider during a hearing, the party must submit that information with its request for reconsideration. This is the party's only opportunity to submit information during the administrative appeals process; the party will not have another opportunity to do so unless an ALJ specifically allows the party to do so under 42 C.F.R. § 498.56(e).

5. Issuance of Reconsideration Determination

The hearing officer shall issue a written decision within 90 calendar days of the date of receipt of the accepted reconsideration request. The hearing officer shall email and mail a hard copy of the reconsideration decision to the provider or supplier or the individual that submitted the reconsideration request, unless an email address is unavailable or the email is returned, then only a hard copy letter should be mailed to the return address on the reconsideration request/envelope or the mailing address on the provider's/supplier's enrollment record if no return address is included on the reconsideration request. The MAC should also fax the CAP decision letter if a valid fax number is available. The

reconsideration letter shall follow the applicable model letter and include:

- The regulatory basis to support each reason for the initial determination;
- A summary of the documentation that the provider or supplier provided, as well as any additional documentation reviewed as part of the reconsideration process;
- The re-stated facts and findings, including the regulatory basis for the action as determined by the contractor in its initial determination;
- A clear explanation of why the hearing officer is upholding or overturning the initial determination in sufficient detail for the provider or supplier to understand the hearing officer's decision and, if applicable, the nature of the provider's or supplier's deficiencies. This explanation should reference the specific regulations and/or sub-regulations supporting the decision, as well as any documentation reviewed;
- If applicable, an explanation of how the provider or supplier does not meet the Medicare enrollment criteria or requirements;
- Further appeal rights, regardless of whether the decision is favorable or unfavorable, procedures for requesting an ALJ hearing, and the addresses to which the written appeal must be mailed or e-mailed. Further appeal rights shall only be provided for reconsideration decisions. There are no further appeals rights related to CAP decisions; and
- Information the provider or supplier must include with its appeal (name/legal business name; supplier number (if applicable); tax identification number/employer identification number (TIN/EIN); NPI; and a copy of the reconsideration decision).

Example 1: If a provider or supplier submits a reconsideration request in response to a revocation pursuant to 42 C.F.R. § 424.535(a)(5), the MAC shall review the initial determination, the enrollment application preceding the site visit, the site investigation report(s), the reconsideration request and supporting documentation, as well as any other relevant information, to determine if an error was made in the implementation of the initial determination (e.g., if an error was made during the site visit, or the site visit was conducted at the wrong location.) If the MAC finds that an error was made during the site visit, which found the provider or supplier to be non-operational, the MAC shall order an additional site visit. If an additional site visit is ordered, the MAC shall await the findings of the site investigator, via the site visit report, before issuing a reconsideration decision. If the site visit report finds the provider or supplier to be

operational then the MAC shall overturn the revocation of the provider's or supplier's Medicare billing privileges as it relates to 42 C.F.R. § 424.535(a)(5) using the applicable model letter.

If the MAC overturns the initial determination, the MAC shall reinstate the provider's or supplier's billing privileges to an approved status as of the effective date determined in the reconsidered determination or continue processing the enrollment application (as applicable). Unless otherwise instructed by PEOG, the MAC shall only send the favorable reconsideration decision to the provider or supplier, authorized or delegated official, or its representative at the return address included on the reconsideration request. The reconsideration decision is sufficient for providing notice to the provider or supplier of the enrollment action being taken. All enrollment updates shall be completed within 10 business days of the date the reconsideration decision was issued or the date of receipt of additional documentation, if needed.

For initial enrollments, the effective date of Medicare billing privileges is based on the date the provider or supplier is found to be in compliance with all Medicare requirements or the receipt date of the application – subject, of course, to any applicable retrospective billing provisions. (See Section 10.6.2 of this chapter for more information.) The MAC shall use the receipt date of the reconsideration request as the receipt date entered in the Provider Enrollment, Chain and Ownership System (PECOS). For DMEPOS suppliers, the effective date is the date awarded by the NSC.

The MAC shall ensure that the applicable CMS Regional Office is notified of the outcome of any reconsideration decision that involves the revocation of Medicare billing privileges for a certified provider or supplier.

If additional information/documentation is needed prior to reinstating the provider or supplier, the MAC shall document these next steps in their reconsideration decision letter. The MAC shall not reinstate the provider's or supplier's enrollment until the requested information is received and processed. If the additional information/documentation is not received within 30 calendar days of the date of the reconsideration decision letter, the MAC shall contact the provider or supplier via the applicable model letter to again request the additional information/documentation within 10 calendar days of not receiving a response. If no response is received within 30 calendar days of the second request for additional information/documentation, the MAC shall contact ProviderEnrollmentAppeals@cms.hhs.gov within 10 calendar days for further instruction.

6. Withdrawal of Reconsideration Request

The provider, 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 of a reconsideration request must be postmarked prior to the reconsideration decision date. The request to withdraw the reconsideration request must be made in writing, signed, and filed with the MAC or CMS. If the MAC receives a request to withdraw a reconsideration request, it shall send

a letter or e-mail to the provider or supplier acknowledging receipt of the request to withdraw the reconsideration request and advising that the request has been dismissed, utilizing the applicable model letter.

7. Requests for Reversal under 42 C.F.R. § 424.530(c)/424.535(e)

Under 42 C.F.R. § 424.530(c)/424.535(e), a provider or supplier may request reversal of a denial of enrollment or revocation of billing privileges if the denial or revocation was due to adverse activity (sanction, exclusion, or felony) against an owner, managing employee, or an authorized or delegated official; or a medical director, supervising physician, or other personnel of the provider or supplier furnishing Medicare reimbursable services. The revocation may be reversed, at the discretion of CMS, if the provider or supplier terminates and submits proof that it has terminated its business relationship with the individual against whom the adverse action is imposed within 30 days of the initial determination. Information that may provide sufficient proof includes, but is not limited to, state corporate filings, IRS documentation, sales contracts, termination letters, evidence of unemployment benefits, board governance documents, and payroll records.

If the MAC receives a CAP and/or reconsideration request from a provider or supplier to reverse or rescind a denial or enrollment or revocation due to the termination of the business relationship between the provider or supplier and the individual against whom the adverse action is imposed, the MAC shall not take any action. The MAC shall forward the CAP and/or reconsideration request to ProviderEnrollmentAppeals@cms.hhs.gov within 10 business days of receipt. The MAC shall not take any action pursuant to the request until further instruction is provided by CMS.

8. Not Actionable CAPs and Reconsideration Requests

If the issue in the initial determination is resolved prior to a CAP and/or reconsideration decision being rendered, the basis of the initial determination may become moot and the CAP and/or reconsideration request will be not actionable. The MAC will be notified if an action has been taken that would render a CAP and/or reconsideration request not actionable as CMS would contact the MAC to rescind the revocation or reinstate the provider or supplier's Medicare billing privileges. If the MAC receives such a notification, then the MAC shall review to determine if a CAP and/or reconsideration request has become not actionable. If so, the MAC shall send a hard copy letter should be mailed to the return address on the CAP or reconsideration request, as well as the provider's or supplier's correspondence address using the applicable not actionable model letter. The MAC shall also send an email if a valid email address is available. The MAC may also send via fax if a valid fax number is available. The MAC shall attach a copy of the letter informing the provider or supplier of the enrollment action which led to the CAP and/or reconsideration request becoming not actionable. If there is a scenario not captured in the not actionable model letter and the MAC believes a CAP and/or reconsideration request has become not actionable, the MAC should email ProviderEnrollmentAppeals@cms.hhs.gov for guidance.

9. Requesting Guidance Related to CAPs and Reconsideration Requests

If the MAC encounters a situation that is not addressed by these instructions, the MAC shall contact the ProviderEnrollmentAppeals@cms.hhs.gov inbox for guidance before taking any action.

D. Further Appeal Rights for Reconsidered Determinations

1. Administrative Law Judge (ALJ) Hearing

The CMS or a provider or supplier dissatisfied with a reconsidered determination is entitled to review by an ALJ with the CRD DAB. The ALJ has delegated authority from the Secretary of the Department of Health and Human Services (DHHS) to exercise all duties, functions, and powers relating to holding hearings and rendering decisions. Such an appeal must be filed, in writing, within 60 days from receipt of the reconsideration decision. To request final ALJ review, the provider or supplier must file an appeal with the Civil Remedies Division of the Departmental Appeals Board within 60 calendar days after the date of receipt of this decision. A provider or supplier may file an appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at <https://dab.efile.hhs.gov/>.

To file a new appeal using DAB E-File, the provider or supplier must first register a new account by:

- (a) Clicking Register on the DAB E-File home page;
- (b) Entering the information requested on the “Register New Account” form; and
- (c) Clicking Register Account at the bottom of the form. If the provider or supplier has more than one representative, each representative must register separately to use DAB E-File on his/her/its behalf.

The e-mail address and password provided during registration must be entered on the login screen at https://dab.efile.hhs.gov/user_sessions/new to access DAB E-File. A registered user’s access to DAB E-File is restricted to the appeals for which he or she is a party or authorized representative.

Once registered, a provider or supplier may file an appeal by logging in and:

- Clicking the File New Appeal link on the Manage Existing Appeals screen, and then clicking Civil Remedies Division on the File New Appeal screen; and
- Entering and uploading the requested information and documents on the “File New Appeal – Civil Remedies Division” form.

All documents must be submitted in PDF form. More detailed instructions on DAB E-File for CRD cases can be found by clicking the CRD E-File Procedures link on the

File New Appeal Screen for CRD appeals.

Pursuant to 42 C.F.R. § 405.809(a)(2), a provider or supplier may not appeal an adverse determination for a CAP, if one was made.

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

Upon receipt of a request for an ALJ hearing, an ALJ at the CRD DAB will issue a letter by certified mail to the supplier, CMS and the OGC acknowledging receipt of an appeals request and detailing a scheduled pre-hearing conference. The OGC will assign an attorney to represent CMS during the appeals process; he/she will also serve as the DAB point of contact. Neither CMS nor the Medicare contractor are required to participate in the pre-hearing conference, but should coordinate among themselves and the OGC attorney prior to the pre-hearing to discuss any issues. The MAC shall work with and provide the OGC attorney with all necessary documentation. This includes compiling and sending all relevant case material to the OGC attorney upon the latter's request within 5 calendar days of said request.

Any settlement proposals, as a result of the pre-hearing conference, will be addressed with CMS. If CMS agrees to settle a provider enrollment appeal, CMS will notify the contractor of appropriate next steps (e.g. changing the effective date of billing privileges or reinstating a provider's billing privileges). This may result in PEOG providing specific instructions to the contractor to modify model letter language to appropriately notify the provider of changes to its enrollment status, revocation effective date, or effective date of billing privileges.

If an ALJ decision is rendered that overturns and/or modifies the initial determination establishing an effective date, revocation or denial of billing privileges, or remands a case back to CMS, this may also result in PEOG providing specific instructions to the contractor to draft and issue a revised reconsideration decision and/or modify the model letter language to appropriately notify the provider or supplier of changes to its enrollment status, revocation effective date, or effective date of billing privileges.

The MAC shall complete all steps associated with the settlement or ALJ decision no later than 10 business days from the date it received PEOG's specific instructions.

2. Departmental Appeals Board (DAB) Hearing

The CMS or a provider/supplier dissatisfied with the ALJ hearing decision may request a Board review by the DAB. Such a request must be filed within 60 days after the date of receipt of the ALJ's decision. Failure to timely request a DAB review is deemed to be a waiver of all rights to further administrative review.

The DAB will use the information in the case file established at the reconsideration level and any additional evidence introduced at the ALJ hearing to make its determination. The DAB may admit additional evidence into the record if the DAB considers it relevant and material to an issue before it. Before such evidence is

admitted, notice is mailed to the parties stating that evidence will be received regarding specified issues. The parties are given a reasonable time to comment and to present other evidence pertinent to the specified issues. If additional information is presented orally to the DAB, a transcript will be prepared and made available to any party upon request.

When CMS receives a decision or order from the DAB, as appropriate, PEOG will notify the MAC of appropriate next steps (i.e. changing an effective date or reinstating a provider's billing privileges). This may also result in PEOG providing specific instructions to the contractor to draft and issue a revised reconsideration decision and/or modify the model letter language to appropriately notify the provider of changes to its enrollment status, revocation effective date, or effective date of billing privileges.

The MAC shall complete all steps associated with the DAB decision no later than 10 business days from the date it received PEOG's specific instructions.

3. Judicial Review

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

E. External Monthly Reporting Requirements for CAPs and Reconsideration Requests

Using the provider enrollment appeals reporting template, the MAC shall complete all columns listed for all appeal submissions except those submissions that are referred to CMS for processing (CAPs and reconsideration requests). No column shall be left blank. If the contractor is unable to complete all columns for a given appeal submission, the contractor shall contact ProviderEnrollmentAppeals@cms.hhs.gov within five business days of discovery to seek further guidance.

The response in column A labelled, "Initial Determination Type," shall be one of the following:

- **Denial:** CAP or Reconsideration Request that challenges the denial of a Medicare enrollment application pursuant to 42 C.F.R. § 424.530(a)(1)-(15).
- **Revocation:** CAP or Reconsideration Request that challenges the revocation of Medicare billing privileges or provider/supplier number pursuant to 42 C.F.R. § 424.535(a)(1)-(22).
- **Effective Date:** Reconsideration request that challenges an initial determination that establishes an effective date of participation in the Medicare program, including the effective date of reactivation after deactivation.

- **Other:** CAP or reconsideration request that does not fall under the three categories listed above. If other is listed, an explanation shall be provided in the “Comments” column N and “N/A” in column G.

The response in Column L labelled, “Final Decision Result,” shall be one of the following (If a final decision has not been issued, the column shall read as “In Process.” If the appeal submission is referred to CMS for processing then the appeal should not be included on the MAC Monthly Appeals Report

- 1. Not Actionable:** Appeal is no longer actionable (moot) because the basis for the initial determination has been resolved. (Ex: Fingerprints have received a passed designation, initial determination has been reopened and revised).
- 2. Favorable (to provider/supplier):** MAC has determined that an error was made in the implementation of the initial determination. Therefore, the initial determination was overturned and the enrollment record has been placed in approved status, the effective date modified, or application processing has continued.
- 3. Unfavorable (to provider/supplier):** MAC upholds the initial determination resulting in the enrollment remaining in a revoked or denied status, or the effective date remaining the same.
- 4. Dismissed:** The appeal does not meet the appeal submission requirements. (Ex: incorrect signature, untimely, not appealable, etc.)
- 5. Rescinded:** MAC has received instruction from CMS to rescind the initial determination and return the enrollment record to an approved status.
- 6. Withdrawn:** Provider/supplier has submitted written notice of its intent to withdraw its appeal (CAP or reconsideration request).

The response in Column M labelled, “Date Final Decision Issued,” shall be “In Process” if a final decision has not been issued at the time the monthly report is sent to CMS.

The response in Column K labelled, “Date Receipt Acknowledgement Sent to Provider/Supplier/Legal Representative,” shall be “Not yet sent” if a receipt acknowledgement email/letter has not been sent to the provider/supplier/legal representative at the time the monthly report is sent to CMS. The response shall be “N/A” if a receipt acknowledgement email/letter is not required for that case. The response in Column F labelled, “MAC (Including Jurisdiction),” shall be in one of the following formats:

- 1. CGS**

- 2. FCSO**
- 3. NGS JK**
- 4. NGS J6**
- 5. Palmetto JM**
- 6. Palmetto JJ**
- 7. NSC**
- 8. WPS J8**
- 9. WPS J5**
- 10. Noridian JE**
- 11. Noridian JF**
- 12. Novitas JL**
- 13. Novitas JH**

The response in Column G, “Regulatory Authority (As identified on initial determination),” shall be in the following format (the authorities will need to be modified based on the type of initial determination):

- For Effective Date appeal: 424.520;
- For Denial appeal with only one authority cited in the initial determination: 424.530(a)(1-15);
- For Denial appeal with multiple authorities cited in the initial determination: 424.530(a)(1-15)(1-15)
- For Revocation appeal with only one authority cited in the initial determination: 424.535(a)(1-22)
- For Revocation appeal with multiple authorities cited in the initial determination: 424.535(a)(1-22)(1-22).
- For Other appeal: N/A with an explanation in the Comments column N.

The reports shall be sent to CMS via email at ProviderEnrollmentAppeals@cms.hhs.gov no later than the 15th of each month; the report shall include the prior month’s appeal submissions, as well as outcomes for all submissions previously received that were not yet completed and reported to CMS (e.g., the February report shall cover all January CAPs/reconsideration requests). All submissions shall remain on the monthly report until a final outcome/decision has been reported to CMS. If this day falls on a weekend or a holiday, the report must be

submitted the following business day.

10.6.19 – Other Medicare Contractor Duties

(Rev. 10735; 04-27-21; Effective: 05-27-21; Implementation: 05-27-21)

The contractor shall adhere to all of the instructions in this chapter 10 (hereafter generally referred to as “this chapter”) and all other CMS provider enrollment directives (e.g., Technical Direction letters). The contractor shall also assign the appropriate number of staff to the Medicare enrollment function to ensure that all such instructions and directives - including application processing timeframes and accuracy standards - are complied with and met.

A. Training

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

- An overview of the Medicare program
- A review of all applicable regulations, manual instructions, and other CMS guidance
- A review of the contractor’s enrollment processes and procedures
- Training regarding the Provider Enrollment, Chain and Ownership System (PECOS).

For new employees, the contractor shall also:

- Provide side-by-side training with an experienced provider enrollment analyst
- Test the new employee to ensure that he or she understands Medicare enrollment policy and contractor processing procedures, including the use of PECOS
- Conduct end-of-line quality reviews for 6 months after training or until the analyst demonstrates a clear understanding of Medicare enrollment policy, contractor procedures, and the proper use of PECOS.

For existing employees, periodic quality reviews and refresher trainings shall be performed by the contractor on a periodic basis.

B. PECOS

The contractor shall:

- Process all enrollment actions (e.g., initials, changes, revalidations, revocations, appeals, denials) through PECOS
- Deactivate or revoke the provider or supplier's Medicare billing privileges in the Multi-Carrier System or the Fiscal Intermediary Shared System only if the provider or supplier is not in PECOS, if the provider does not exist in MCS or FISS, prior to taking action contact CMS
- Close or delete any aged logging and tracking (L & T) records older than 120 days for which there is no associated enrollment application
- Participate in user acceptance testing for each PECOS release
- Attend scheduled PECOS training when requested
- Report PECOS validation and production processing problems through the designated tracking system for each system release
- Develop (and update as needed) a written training guide for new and current employees on the proper processing of Form CMS-855, CMS-20134 applications, opt out affidavits, and the appropriate entry of data into PECOS.

C. Customer Service

1. Responding to Provider Enrollment Inquiries

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

- Application status checks (e.g., "Has the contractor finished processing my application?") (The contractor may wish to establish electronic mechanisms by which providers can obtain updates on the status of their enrollment applications via the contractor's Web site or automated voice response (AVR).
- Furnishing information on where to access the Form CMS-855 or CMS-20134 applications (and other general enrollment information) on-line
- Explaining to providers/suppliers which Form CMS-855 or CMS-20134 applications should be completed.

2. Contractor's Responsiveness to Inquiries

Excluding matters pertaining to application processing (e.g., development for missing data) and appeals (e.g., appeal of revocation), the contractor is encouraged to respond to

all enrollment-related provider/supplier correspondence (e.g., e-mails, letters, telephone calls) within 30 business days of receipt.

D. Contractor Outreach to Providers

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

E. Encouraging Use of Internet-based PECOS

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

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

F. Adherence to Responsibilities Based Upon Jurisdiction

1. Audit and Claims Contractors

a. Background

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

Should the audit and claims contractors differ, the audit contractor shall process all changes of information, including all Form CMS-588 changes. The audit contractor shall notify the applicant during the initial enrollment process that all future changes of information must be sent to the audit contractor, not the claims contractor. If the provider inadvertently sends a change request to the claims contractor, the latter shall return the application per section 10.4(H)(1) of this chapter.

b. Process

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

- (i) Send an e-mail to the claims contractor identifying the specific Form CMS-855A transaction involved and confirming that the information has been updated in the Provider Enrollment, Chain and Ownership System (PECOS). Pertinent identifying information, such as the provider name, CMS Certification Number and National Provider Identifier, shall be included in the e-mail notification. If the e-mail contains any supporting documentation that contains personal health information or personally identifiable information the audit contractor shall encrypt the e-mail prior to sending.
- (ii) As applicable, fax, mail, or email an encrypted copy of the submitted Form CMS-588 to the appropriate claims contractor.

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

The audit contractor shall keep all original copies of Form CMS-855A paperwork and supporting documentation, including all Form CMS-588s.

c. Tie-In/Tie-Out Notices and Approval Notices

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

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

G. Online Presence – Web Sites

The contractor must provide a link to CMS' provider/supplier enrollment Web site located at <https://www.cms.gov/medicare/provider-enrollment-and->

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

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

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

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/contact_list.pdf

If the contractor services several States with a universal address and telephone number, the contractor shall report that information. In situations where no actions are required, a response from the contractor is still required (i.e., the contact information is accurate). In addition, only such information that pertains to provider enrollment activity for the contractor's jurisdiction is to be reported. All updates shall be sent directly via e-mail to the contractor's CMS PEOG Business Function Lead (BFL).

H. Document Retention

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

Supporting documentation includes, but is not limited to:

- Copies of Federal, State and/or local (city/county) professional licenses, certifications and/or registrations;

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

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

1. Provider/Supplier and Durable Medical Equipment Supplier Application

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

Disposition: Destroy when 7 years old.

b. Approved applications of provider/supplier

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

c. Denied applications of provider/supplier.

Disposition: Destroy 15 years after the date of denial.

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

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

e. Voluntary deactivation of billing number

Disposition: Destroy 15 years after deactivation.

f. Provider/Supplier dies

Disposition: Destroy 7 years after date of death.

2. Electronic Mail and Word Processing System Copies

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

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

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

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

I. Keeping Record of Activities

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

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

J. Keeping Record of Written and Telephonic Communications

(For purposes of this section 10.6.19(H), “written correspondence” includes mailed, faxed, and e-mailed correspondence.)

K. Keeping Record of Written Correspondence

The contractor shall:

- Retain copies of all written correspondence pertaining to the provider, regardless of whether the correspondence was initiated by the contractor, the provider, CMS, State officials, etc.
- Document when it sends written correspondence to providers. For instance, if the contractor crafts an approval letter to the supplier dated March 1 but sends it out on March 3, the contractor shall note this in the file.
- Document all referrals to CMS, the UPIC, or the OIG

L. Keeping Record of Telephonic or Face-to-Face Contact

Telephonic or Face-to-Face Contact is hereafter referred to as “oral communication.”

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

- Telephoning a provider about its application. (Even if the provider official was unavailable and a voice mail message was left, this must be documented.)
- Requesting information from the state or another contractor concerning the applicant or enrollee
- Contacting the UPIC for an update concerning a particular case
- Phone calls from the provider
- Conducting a meeting at the contractor's headquarters/offices with officials from a hospital concerning problems with its application
- Telephoning PEOG or the RO (e.g., the RO's survey and certification staff) and receiving instructions therefrom about a problem the contractor is having with an applicant or an existing provider
- Telephoning the provider's billing department with a question about the provider.

When documenting oral communications, the contractor shall indicate: (1) the time and date of the call or contact; (2) who initiated the contact; (3) who was spoken with; and (4) what the conversation pertained to. Concerning the last requirement, the contractor need not write down every word that was said during the conversation. Rather, the documentation should merely be adequate to reflect the contents of the conversation. The documentation can be crafted and stored electronically if the contractor can provide access within 24 hours upon request.

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

If an application is returned per section 10.4(H)(1) of this chapter, the contractor shall document this. The manner of documentation lies within the contractor's discretion.

M. Documenting Verification of Data Elements

Once the contractor has completed its review of the CMS-855, CMS-20134 applications,(e.g., approved/denied application, approved change request) and Opt Out Affidavits, it shall document that it has: (1) verified all data elements on the

application, and (2) reviewed all applicable names on the above mentioned forms against the OIG/LEIE and the System for Access Management (SAM). It can be drafted in any manner the contractor chooses so long as it certifies that the above-mentioned activities were completed. The record can be stored electronically.

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

N. Release of Information

On October 13, 2006, CMS published System of Records Notice for the Provider Enrollment, Chain and Ownership System (PECOS) in the Federal Register. Consistent with this notice, once the provider has submitted an enrollment application (as well as after it has been enrolled), the contractor shall not release – either orally or in writing - provider-specific data to any outside person or entity, unless specified otherwise in this chapter. (Provider-specific data includes, but are not limited to, owners/managers, adverse legal history, practice locations, group affiliations, effective dates, etc.) Examples of outside persons or entities include, but are not restricted to, national or state medical associations or societies, clearinghouses, billing agents, provider associations, or any person within the provider's organization other than the provider's authorized official(s) (section 15 of the CMS-855 and CMS-20134), delegated official(s) (section 16), or contact persons (section 13). The only exceptions to this policy are:

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

(These provisions also apply in cases where the provider requests a copy of any Form CMS-855 or CMS-20134 paperwork the contractor has on file.)

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

- The following information shall be made available over-the-phone to a caller who is able to provide a provider/suppliers name, PTAN, TIN/SSN and NPI

number. The caller does not need to be listed on the provider/supplier's enrollment record as a contact person:

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

In addition:

- When sending emails, the contractor shall not transmit sensitive data, such as social security numbers or employer identification numbers, without first encrypting the email.
- The contractor may not send PECOS screen printouts to the provider.
- With the exception of CMS-855S applications, if any contact person listed on a provider or supplier's enrollment record, requests a copy of a provider or supplier's Medicare approval letter or revalidation notice, the contractor shall send to the contact person via email, fax or mail. This excludes Certification Letters (Tie In notices), as the contractor is not responsible for generating these approvals.

O. Security

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

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

All contractor staff shall be trained on security procedures as well as relevant aspects of the Privacy Act and the Freedom of Information Act. This applies to all management, users, system owners/managers, system maintainers, system developers, operators and administrators - including contractors and third parties - of CMS information systems, facilities, communication networks and information.

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

P. Contractor to Contractor Communications

Medicare contractors create Associate and Enrollment Records in the Provider Enrollment, Chain and Ownership System (PECOS). Ownership of an Associate or Enrollment Record belongs to the contractor within whose jurisdiction the provider/supplier is located. PECOS only permits the contractor that created the Associate or Enrollment Record (the “owning contractor”) to make updates, changes, or corrections to those records. (That is, the owning contractor is the only contractor that can make changes to the associate record.)

Occasionally, updates, changes, or corrections do not come to the owning contractor’s attention, but instead go to a different contractor. In those situations, the contractor that has been notified of the update/change/correction (the “requesting” contractor) must convey the changed information to the owning contractor so that the latter can update the record in PECOS.

The requesting contractor may notify the owning contractor via fax or email (encrypted if it contains personally identifiable information) of the need to update/change/correct information in a provider’s PECOS record. The notification must contain:

1. The provider’s legal business name, Provider Transaction Access Number, and National Provider Identifier; and
2. The updated/changed/corrected data (by including a copy of the appropriate section of the Form CMS-855 or CMS-20134).

Within 7 calendar days of receiving the requesting contractor’s request for a change to a PECOS record, the owning contractor shall make the change and notify the requesting contractor thereof via fax, e-mail, or telephone.

If the owning contractor is reluctant to make the change, it shall contact its CMS Provider Enrollment & Oversight Group (PEOG) BFL for guidance. Note that the owning contractor may ask the requesting contractor for any additional information about the provider it deems necessary (e.g., IRS documentation, licenses).

The owning contractor need not ask the provider for a Form CMS-855 or CMS-20134 change of information in associate profile situations. It can simply use the Form CMS-855 or CMS-20134 copy that the requesting contractor sent/faxed to the owning contractor. For instance, suppose Provider X is enrolled in two different contractor jurisdictions – A and B. The provider enrolled with “A” first; its legal business name was listed as “John Brian Smith Hospital.” It later enrolls with “B” as “John Bryan Smith Hospital.” “B” has verified that “John Bryan Smith Hospital” is the correct name and sends a request to “A” to fix the name. “A” is not required to ask the provider to submit a Form CMS-855A change of information. It can use the CMS-855A copy that it received from “B.”

Q. Establishment of Relationships

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

R. Ongoing Monitoring Activities

1. Monitoring Information from State Licensing Boards

To help ensure that only qualified physicians and non-physician practitioners are enrolled in Medicare, the contractor shall undertake the activities described below.

For purposes of this section, the term “practitioner” includes both physicians and non-physician practitioners. In addition, the instructions in this section, apply only to these practitioners.

a. Monthly Reviews

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

- Had their medical license revoked, suspended or inactivated (due to retirement, death, or voluntary surrender of license);
- Otherwise lost their medical license or have had their licenses expire.
- For those practitioners who no longer have a valid medical license, the contractor shall take the necessary steps pursuant to guidance in this chapter.
- The mechanism by which the contractor shall perform these monthly licensure reviews lies within its discretion, though the most cost-effective method shall be used.

S. Regarding Potential Identity Theft or Other Fraudulent Activity

In conducting the verification activities described in section 10.6.19(H) of this chapter, 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 CMS Provider Enrollment & Oversight Group Business Function Lead (PEOG BFL) immediately; the BFL will instruct the contractor as to what, if any, action shall be taken

T. Medicare Contractor Duties – Reporting Requirements

1. Contractor Reporting Requirements

a. Monthly Rebuttal Reporting Requirements

Using the rebuttal reporting template, the contractor shall complete all columns listed for all rebuttal submissions. No column shall be left blank. If the contractor is unable to complete all columns for a given rebuttal submission, the contractor shall contact ProviderEnrollmentAppeals@cms.hhs.gov within five business days of discovery to seek further guidance.

The response in column J labelled, “Final Decision Result” shall be one of the following (If a final decision has not yet been rendered at the time the report is due to CMS, the status shall read as “In Process.”):

- **Not Actionable:** Rebuttal is no longer actionable (moot) because the basis for the deactivation has been resolved.
- **Favorable (to provider/supplier):** MAC has determined that an error was made in the implementation of the deactivation. Therefore, the deactivation was not justified and the enrollment record has been placed back into an approved status.
- **Unfavorable (to provider/supplier):** MAC has determined that the deactivation was justified and the enrollment record remains deactivated.
- **Dismissed:** The appeal does not meet the rebuttal submission requirements. (Ex: incorrect signature, untimely, not rebuttable, etc.
- **Rescinded:** MAC has received instruction from CMS to rescind the deactivation and return the enrollment record to an approved status.
- **Withdrawn:** Provider/supplier has submitted written notice of its intent to withdraw its rebuttal.

The response in Column I labelled, “Date Rebuttal Determination Issued,” shall be “In Process” if a rebuttal decision has not been issued at the time the rebuttal report is sent to CMS.

The response in Column H labelled, “Date Receipt Acknowledgement

Sent to Provider/Supplier/Legal Representative,” shall be “Not yet sent” if a receipt acknowledgement email/letter has not been sent to the provider/supplier/legal representative at the time the monthly report is sent to CMS. The response shall be “N/A” if a receipt acknowledgement email/letter is not required for that case.

The response in Column E labelled, “MAC (Including Jurisdiction),” shall be in one of the following formats:

- 1. CGS**
- 2. FCSO**
- 3. NGS JK**
- 4. NGS J6**
- 5. Palmetto JM**
- 6. Palmetto JJ**
- 7. NSC**
- 8. WPS J8**
- 9. WPS J5**
- 10. Noridian JE**
- 11. Noridian JF**
- 12. Novitas JL**
- 13. Novitas JH**

The response in Column F labelled, “Regulatory Authority (As identified on initial determination),” shall be in one the following formats:

- 424.540(a)(1);
- 424.540(a)(2);
- 424.540(a)(3);
- N/A if the rebuttal was submitted in response to an enrollment action that does not afford rebuttal rights. If N/A is used in Column F, then an explanation shall be provided in Column K labelled, “Comments.”

The reports shall be sent to CMS via email at ProviderEnrollmentAppeals@cms.hhs.gov no later than the 15th of each month; the report shall include the prior month's rebuttal submissions, as well as outcomes for submissions previously received that were not yet completed and reported to CMS (e.g., the February report shall cover all January rebuttals). All submissions shall remain on the monthly report until a final outcome/decision has been reported to CMS. If this day falls on a weekend or a holiday, the report shall be submitted the following business day.

10.6.20 – Screening: On-site Inspections and Site Verifications (Rev. 10524; Issued: 12-17-20; Effective: 11-13-20; Implementation: 11-13-20)

A. On-Site Inspections and Site Verifications of DMEPOS Suppliers and IDTFs

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

B. Other Provider and Supplier Types

For all provider and supplier types – other than DMEPOS suppliers and IDTFs – that are subject to a site visit in accordance with this section 10.6.20, the SVC will perform such visits consistent with the procedures outlined in sections 10.6.20(B) through 10.6.20(F) of this chapter. This includes the following:

- Documenting the date and time of the visit, and including the name of the individual attempting the visit;
- Photographing the provider or supplier's business for inclusion in the provider/supplier's file. All photographs will be date/time stamped;
- Fully documenting observations made at the facility, which could include facts such as: (a) the facility was vacant and free of all furniture; (b) a notice of eviction or similar documentation is posted at the facility, and (c) the space is now occupied by another company;
- Writing a report of the findings regarding each site verification; and
- Including a signed site visit report stating the facts and verifying the completion of the site verification. (The sample identified in this section 10.6.20(F).1 of this chapter is recommended.)

In terms of the extent of the visit, the SVC will determine whether the following criteria are met:

- The facility is open

- Personnel are at the facility
- Customers are at the facility (if applicable to that provider or supplier type)
- The facility appears to be operational

This will require the site visitor(s) to enter the provider or supplier's practice location/site, rather than simply conducting an external review.

If any of the 4 elements listed above are not met, the enrollment contractor will, as applicable - and using the procedures outlined in this chapter and in existing CMS instructions - deny the provider's enrollment application pursuant to §424.530(a)(5)(i) or (ii), or revoke the provider's Medicare billing privileges under §424.535(a)(5)(i) or (ii).

C. Operational Status

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

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

If the MAC is unsure of how to proceed based on their evaluation of the site visit results, they shall contact their CMS Provider Enrollment Oversight Group (PEOG) Business Function Lead (BFL) and copy their Contracting Officer's Representative (COR).

D. Timing

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

E. Documentation

When conducting site verifications to determine whether a practice location is operational, the contractor shall:

- Document the date and time of the attempted visit and include the name of the individual attempting the visit;
- As appropriate, photograph the provider or supplier's business for inclusion in the provider or supplier's file on an as needed basis. All photographs should be date/time stamped;
- Fully document all observations made at the facility (e.g., the facility was vacant and free of all furniture, a notice of eviction or similar documentation was posted at the facility, the space is now occupied by another company); and
- Write a report of its findings regarding each site verification.

F. Determination

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

For non-operational status revocations, the contractor shall use either 42 CFR §424.535(a)(5)(i) or 42 CFR §424.535(a)(5)(ii) as the legal basis for revocation.

Consistent with 42 CFR §424.535(g), the date of revocation is the date on which CMS or the contractor determines that the provider or supplier is no longer operational. The Medicare contractor shall establish a 2-year enrollment bar for suppliers that are not operational.

For regulatory non-compliance revocations, the contractor shall use 42 CFR §424.535(a)(1) as the legal basis for revocation. Consistent with 42 CFR §424.535(g), the date of revocation is the date on which CMS or the contractor determines that the provider or supplier is no longer in compliance with regulatory provisions for their provider or supplier type. The Medicare contractor shall establish a 2-year enrollment bar for the providers and suppliers that are not in compliance with provisions for their enrolled provider or supplier type.

G. Site Visits Performed by the National Supplier Clearinghouse (NSC)

The NSC shall continue to conduct onsite inspections consistent with its Statement of Work and any instructions issued by the NSC project officer.

10.7 – Model Letters

(Rev. 10182; Issued: 06-15-2020; Effective: 09-16-2020; Implementation: 09-16-2020)

The contractor shall use the following letters when rejecting, returning, approving or denying an application, or when revoking an entity's Medicare billing privileges. Any exceptions to this guidance shall be approved by the contractor's CMS Provider Enrollment & Oversight Group Business Function Lead (PEOG BFL), unless specified otherwise. The contractor shall document approval received by their PEOG BFL for QASP purposes.

A. Issuing Letters

1. Model Letter Guidance

Format Requirement

All letters sent by contractors to providers and suppliers shall consist of the following format:

General Guidance

- The CMS logo (2012 version) displayed per previous CMS instructions.
- The contractor's logo shall be displayed however the contractor deems appropriate. There are no restrictions on font, size, or location. The only restriction is that the contractor's logo must not conflict with the CMS logo.
- All text, with the exception of items in the header or footer, shall be written in Times New Roman 12-point font (with the exception of name and address information per USPS requirements).
- All dates in letters, except otherwise specified, shall be in the following format: month/dd/yyyy (e.g., January 26, 2012).
- Letters shall contain fill-in sections as well as static, or "boilerplate" sections. The fill-in sections are delineated by words in brackets in italic font in the model letters.
- The static sections shall be left as-is unless there is specific guidance for removing a section (e.g., removing a CAP section for certain denial and revocation reasons; removing State survey language for certain

provider/supplier types that do not require a survey). If there is no guidance for removing a static section, the contractor must obtain approval from its PEOG BFL to modify or remove such a section.

Approval Letters

- Part A/B certified provider and supplier paper/web COI and revalidation approval recommended letters shall detail the recommended changes (e.g. practice location changed to 123 Main Street, Baltimore MD 21244).
- For COI and revalidation applications that do not require a Tie in or recommendation but require notification to the RO as a cc, the contractor shall add the additional fields applicable to the letter (e.g., cc the RO/state). The contractor should itemize the changes if it is beneficial to the RO.
- Part A/ B and DME provider and supplier paper/web COI and revalidation letters shall only list the section title (at the sub-section level) from the paper/web CMS-855 and CMS-20134 application (e.g., Correspondence Mailing Address, Final Adverse Legal Actions, Remittance Notices/Special Payments Mailing Address, etc.).
- If as part of revalidation, the provider only partially revalidates (i.e., a provider has multiple PTANs, one PTAN is revalidated and the others end dated), contractors shall notate the reassignments that were terminated due to non-response and the effective date of termination (i.e., the revalidation due date or the development due date).
- Contractors shall remove the following language when issuing the Approval – Voluntary Termination (Part A/B Org or Part B Sole Owner) for a Part A/B certified provider, “Reassignments and any physician assistant employment arrangements are also deactivated”, unless other active reassignments/employment arrangements exist on the enrollment.
- If the provider is submitting a change as part of a voluntary termination application (e.g. special payment address, EFT, authorized official), the contractor shall enter the applicable fields into the Medicare Enrollment information table.
- Approval letters may include a generic provider enrollment signature and contact information (e.g. customer service line), however, all development letters shall include a provider enrollment analyst’s name and phone number for provider/supplier contacts.
- Participation status shall only be included in initial and reactivation letters for Part B sole proprietors, Part B sole owners, any Part B organizations and DME suppliers. Change of information approval letters shall only include the

participation status if it was changed as part of the application submission, if applicable.

- Contractors shall add lines to the enrollment information tables on any reactivation letter, if the provider/supplier has reactivated following non-response to a revalidation and enrollment information was changed on the application.
- Contractors shall enter an effective date to all Change of Information approval letters if a new PTAN is issued based on the changes (e.g., a new location is added to a new payment locality).
- Contractors shall add appeal rights to all Change of Information and Revalidation approval letters if a new PTAN is issued based on the changes (e.g., a new location is added to a new payment locality, a new reassignment is created).
- If the provider is revalidating multiple reassignments to different groups, contractor shall add additional lines to the grid to identify the separate groups and PTANs.
- If the provider revalidates both reassignments and one or more sole proprietorship locations, contractors shall add an indication on the appropriate letter to indicate the approval covers the reassignments and sole proprietorships.
- On the Approval Recommended - Initial (Part A/B Certified) letters, contractor should add the “Date Completed CMS-855A Received” to the Medicare enrollment information table for FQHC’s only.
- In CHOW, consolidation, acquisition or merger scenarios, contractor shall use “H. Approval – Voluntary Termination (Part A/B Certified Org)” to notify the seller. Contractors should remove verbiage that refers to “disenrolling”, ending reimbursement and the effective date of termination since the seller is not deactivating their enrollment for no further billing. Contractors should also remove the “CC” line, as the seller’s information is not sent to the SA or RO.
- The term “CHOW” should be added to the enrollment information table for the “F. Change of Information or Change of Ownership (Part A/B Certified) letter when adding a new or updated Medicare Year-End Cost Report date.
- In the Part B Non-Certified provider or supplier letters, contractors shall populate 42 CFR§424.205 for MDPP suppliers or §424.516 for all other providers and suppliers in the following paragraph:

Submit updates and changes to your enrollment information within the timeframes specified at [42 CFR §424.516 or 42 CFR§424.205].

For more information on the reporting requirements, go to Medicare Learning Network Article SE1617.

Denial/Revocation Letters

- The contractor shall populate the fill-in sections with the appropriate information such as primary regulatory citation and specific denial and revocation reasons, names, addresses, etc.
- The fill-in sections shall be indented ½ inch from the normal text of the letter.
- All specific or explanatory reasons shall appear in bold type and shall match the federal registry heading. This applies to headings. For example, if the revocation letter contains the following specific explanatory language, the heading should be in bold type and the explanation should be in normal type, as shown in the excerpt below:

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

Data analysis conducted on claims billed by [Dr. Ambassador], for dates of service [Month XX, XXXX], to [Month XX, XXXX], revealed that [Dr. Ambassador] billed for services provided to [XX] Medicare beneficiaries who were deceased on the purported date of service.

- There may be more than one primary reason listed.

The following letter revisions do not require prior PEOG BFL approval:

- If the contractor cannot format the enrollment information table as provided in these model letters, contractors may provide the information in a similar non-table format.
- Placing a reference number or numbers between the provider/supplier address and the salutation (contractors can include their document control number and the Web Tracking ID in this field, if the application was received via Internet-Based PECOS).
- Contractors shall enter “N/A” or leave information blank on the enrollment information table if the field does not apply (e.g., Doing Business As (DBA), effective date for changes).
- Contractors shall include the applicable PTAN and NPI for the application submission on the letter. If multiple PTANs or NPIs apply, the contractor should: (1) enter “multiple” in the PTAN and NPI fields, (2) copy and add additional PTAN/NPI rows to the enrollment information tables, or (3)

attach a list of any and all PTAN and NPI combinations that apply in the letter.

- In the case of an individual revalidation, where multiple PTANs may be revalidating from multiple reassignments or individual associations, the contractor may also list the Group Legal Business Name (LBN) and PTAN Effective Date in connection with the appropriate individual NPI and PTAN combinations. Contractors may use flexibility in relaying these fields when multiplicities exist, ensuring they meet the reporting requirements of the template.
- Appropriate documents attached to specific letters as needed.
- Placing language in any letter regarding self-service functions such as the Provider Contact Center Interactive Voice Response (IVR) system and Electronic Data Interchange (EDI) enrollment process.

2. Sending Letters

- The contractor shall issue approval letters within 5 business days of approving the application in PECOS.
- For all applications, other than the Form CMS-855S, the contractor shall send development/approval letters, etc., to the contact person if one is listed; otherwise, the contractor may send the letter to the provider or supplier at the email, mailing address or fax provided in the correspondence address or special payments address sections.
- Contractors may insert an attention field with the contact's name as part of the mailing address but the letter should still be addressed to the provider. The National Supplier Clearinghouse shall continue to send letters to the supplier's correspondence address until their automated process can be updated to include the contact person as a recipient of the letters.
- If the provider submits two CMS-855Rs concurrently, two separate approval letters shall be issued (one for each of the group reassignments).
- For initial, change of information, revalidation and voluntary termination applications submitted by sole owners, contractor should issue one approval letter, however, the Medicare enrollment information table shall distinctly list the individual and sole owner information.
- If as part of revalidation, a physician assistant is adding and terminating an employment relationship, one letter shall be issued (approving the

revalidation). However, the termination and additional employment relationship shall be noted in the approval letter.

- The contractor shall issue all denial and revocation letters via certified mail.

10.7.1 – Acknowledgement Letters

(Rev. 10524; Issued: 12-17-20; Effective: 11-13-20; Implementation: 11-13-20)

A. Acknowledgement Letter Guidance

Sending an acknowledgement letter is optional.

B. Model Acknowledgement Letter

1. Acknowledgement Example – Application Receipt

[month] [day], [year]

[Provider/Supplier Name]

[Address]

[City] ST [Zip]

Reference ID: (Case #, Control Number, etc.)

Dear [Provider/Supplier Name]:

Your Medicare enrollment application(s) was received on [date] and [is/are] currently being reviewed. You will receive a letter within 30 calendar days if we need any additional information.

Additional provider/supplier identification information: NPI, DBA Name, etc.

Please retain this letter in case you must submit additional information to support your application. If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM]

Sincerely,

[Name]

[Title]

[Company]

10.7.2 – Development Letters

(Rev. 10723; Issued: 04-08-21; Effective: 07-27-20; Implementation: 08-10-20)

A. Development Letter Guidance

In the following sentence:

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

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

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

B. Model Development Letters

1. Development Example

[month] [day], [year]

[Provider/Supplier Name]

[Address]

[City] ST [Zip]

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

Dear [Provider/Supplier Name]:

We have received your Medicare enrollment application(s). We may reject your application(s) if you do not furnish complete information within 30 calendar days from the postmarked date of this letter pursuant to 42 CFR §424.525. In order to complete processing your application(s), please make the following revisions and/or supply the requested supporting documentation:

[Specify revisions and/or supporting documentation needed]

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

[Name of MAC]

[Address]

[City], ST [Zip]

Finally, please attach a copy of this letter with your revised application(s). If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM.]

Sincerely,

[Name]
[Title]
[Company]

2. Certified Provider/Supplier Voluntary Termination Development Letter

[month] [day], [year]

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

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

Dear [Provider/Supplier Name]:

We were notified by the [insert State Agency name] that on [date of site survey] the State Agency attempted to verify if your [insert type of provider] is operational. The State Agency has reported that your facility was closed, not operational and ceased business at your address of record.

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

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

State Agency Name
Address
City State Zip

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

If we do not hear from you, your Medicare enrollment and corresponding Provider Agreement will be terminated, pursuant to 42 CFR §489.52(b)(3).

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

Sincerely,

[Name]

[Title]

[Company]

10.7.3 – Approval Letters

(Rev. 10182; Issued: 06-15-2020; Effective: 09-16-2020; Implementation: 09-16-2020)

Contractors shall use the formatting instructions found in Section 10.7 of this chapter to complete and issue approval letters for all provider and supplier types.

10.7.4 – DME Approval Letter Templates

(Rev. 10182; Issued: 06-15-2020; Effective: 09-16-2020; Implementation: 09-16-2020)

A. Approval – Change of Information (DME)

[Month, Day, Year]

[Provider/Supplier Name]

[Address]

[City, State, Zip]

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor] approved your Change of Information (COI) application.

Medicare Enrollment Information

| | |
|---|--|
| Supplier Legal Business Name (LBN) | |
| Doing Business As (DBA) | |
| Physical Location Address | |
| Supplier Type | |
| National Provider Identifier (NPI) | |
| Provider Transaction Access Number (PTAN) | |
| PTAN Effective Date | |
| Changed Information | Include detailed changes or section titles, as applicable. |

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

Filing claims electronically? Contact the Common Electronic Data Exchange (CEDI) Contractor at www.ngscedi.com or (866) 311-9184.

Subscribe to receive timely listserv messages regarding Medicare billing policies at:

- Jurisdiction A – Noridian Healthcare Solutions, med.noridianmedicare.com/web/jadme
- Jurisdiction B – CGS, www.cgsmedicare.com
- Jurisdiction C – CGS, www.cgsmedicare.com
- Jurisdiction D – Noridian Healthcare Solutions, med.noridianmedicare.com/web/jddme

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

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

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

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

Sincerely,

[Name]
[Title]
[Company]

B. Approval – Initial (DME)

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor] approved your initial enrollment application.

Medicare Enrollment Information

| | |
|---|--|
| Supplier Legal Business Name (LBN) | |
| Doing Business As (DBA) | |
| Physical Address Location | |
| Supplier Type | |
| National Provider Identifier (NPI) | |
| Provider Transaction Access Number (PTAN) | |
| PTAN Effective Date | |
| Participation Status | |

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

Filing claims electronically? Contact the Common Electronic Data Exchange (CEDI) Contractor at www.ngscedi.com or (866) 311-9184.

Subscribe to receive timely listserv messages regarding Medicare billing policies at:

- Jurisdiction A – Noridian Healthcare Solutions, med.noridianmedicare.com/web/jadme
- Jurisdiction B – CGS, www.cgsmedicare.com
- Jurisdiction C – CGS, www.cgsmedicare.com
- Jurisdiction D – Noridian Healthcare Solutions, med.noridianmedicare.com/web/jddme

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

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

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

Right to Submit a Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. (Optional Coversheet sentence [To facilitate the processing of your reconsideration request, please utilize and

include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.])

Reconsideration requests must:

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

Providers and suppliers may:

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

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

The reconsideration request should be sent to:

(Insert correct address based on whether the MAC or CMS is responsible for handling the reconsideration.

| | | |
|---------------|----|--|
| [Name of MAC] | | [Centers for Medicare & Medicaid Services] |
| [Address] | or | [Provider Enrollment & Oversight Group] |

[City], ST [Zip]

[ATTN: Division of Compliance & Appeals]
[7500 Security Blvd.]
[Mailstop: AR-19-51]
[Baltimore, MD 21244-1850]

Or emailed to:

[Insert MAC email address] or [ProviderEnrollmentAppeals@cms.hhs.gov]

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

Sincerely,

[Name]

[Title]

[Company]

C. Approval – Reactivation (DME)

[Month, Day, Year]

[Provider/Supplier Name]

[Address]

[City, State, Zip]

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor] approved your reactivation application.

Medicare Enrollment Information

| | |
|---|--|
| Supplier Legal Business Name (LBN) | |
| Doing Business As (DBA) | |
| Physical Address Location | |
| Supplier Type | |
| National Provider Identifier (NPI) | |
| Provider Transaction Access Number (PTAN) | |
| PTAN Effective Date | |
| Participation Status | |

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

To file claims electronically, please contact the Common Electronic Data Exchange (CEDI) Contractor at www.ngscedi.com or (866) 311-9184.

Subscribe to receive timely listserv messages regarding Medicare billing policies at:

- Jurisdiction A – Noridian Healthcare Solutions, med.noridianmedicare.com/web/jadme
- Jurisdiction B – CGS, www.cgsmedicare.com
- Jurisdiction C – CGS, www.cgsmedicare.com
- Jurisdiction D – Noridian Healthcare Solutions, med.noridianmedicare.com/web/jddme

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

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

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

Right to Submit a Reconsideration Request:

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

Reconsideration requests must:

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
 - If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
 - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written

notice of the appointment of its representative with the submission of the reconsideration request.

- Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her behalf.

Providers and suppliers may:

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

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

The reconsideration request should be sent to:

(Insert correct address based on whether the MAC or CMS is responsible for handling the reconsideration.

| | | |
|------------------|----|--|
| [Name of MAC] | | [Centers for Medicare & Medicaid Services] |
| [Address] | or | [Provider Enrollment & Oversight Group] |
| [City], ST [Zip] | | [ATTN: Division of Compliance & Appeals] |
| | | [7500 Security Blvd.] |
| | | [Mailstop: AR-19-51] |
| | | [Baltimore, MD 21244-1850] |

Or emailed to:

[Insert MAC email address] or [ProviderEnrollmentAppeals@cms.hhs.gov]

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

Sincerely,

[Name]
[Title]
[Company]

D. Approval – Revalidation (DME)

[Month, Day, Year]

[Provider/Supplier Name]

[Address]

[City, State, Zip]

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor] approved your revalidation application.

Medicare Enrollment Information

| | |
|---|--|
| Supplier Legal Business Name (LBN) | |
| Doing Business As (DBA) | |
| Physical Address Location | |
| Supplier Type | |
| National Provider Identifier (NPI) | |
| Provider Transaction Access Number (PTAN) | |
| PTAN Effective Date | |
| Changed Information | Include detailed changes or section titles, as applicable. |

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

To file claims electronically, please contact the Common Electronic Data Exchange (CEDI) Contractor at www.ngscedi.com or (866) 311-9184.

Subscribe to receive timely listserv messages regarding Medicare billing policies at:

Subscribe to receive timely listserv messages regarding Medicare billing policies at:

- Jurisdiction A – Noridian Healthcare Solutions, med.noridianmedicare.com/web/jadme
- Jurisdiction B – CGS, www.cgsmedicare.com
- Jurisdiction C – CGS, www.cgsmedicare.com
- Jurisdiction D – Noridian Healthcare Solutions, med.noridianmedicare.com/web/jddme

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

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

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

Right to Submit a Reconsideration Request:

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

Reconsideration requests must:

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

Providers and suppliers may:

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

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

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

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

The reconsideration request should be sent to:

(Insert correct address based on whether the MAC or CMS is responsible for handling the reconsideration.

| | | |
|------------------|----|--|
| [Name of MAC] | | [Centers for Medicare & Medicaid Services] |
| [Address] | or | [Provider Enrollment & Oversight Group] |
| [City], ST [Zip] | | [ATTN: Division of Compliance & Appeals] |
| | | [7500 Security Blvd.] |
| | | [Mailstop: AR-19-51] |
| | | [Baltimore, MD 21244-1850] |

Or emailed to:

[Insert MAC email address] or [ProviderEnrollmentAppeals@cms.hhs.gov]

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

Sincerely,

[Name]
[Title]
[Company]

E. Approval – Voluntary Termination (DME)

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor] completed your application to disenroll from the Medicare program.

Medicare Enrollment Information

| | |
|---|--|
| Supplier Legal Business Name (LBN) | |
| Doing Business As (DBA) | |
| Physical Address Location | |
| Supplier Type | |
| National Provider Identifier (NPI) | |
| Provider Transaction Access Number (PTAN) | |
| Effective Date of Termination | |

Medicare will not reimburse you for any claims with dates of service on or after your effective date of termination.

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

Sincerely,

[Name]
[Title]
[Company]

10.7.5 – Part A/B Certified Provider and Supplier Approval Letter Templates

(Rev. 10182; Issued: 06-15-2020; Effective: 09-16-2020; Implementation: 09-16-2020)

A. Approval – Change of Information (Part A/B Certified Org, No Recommendation Required)

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

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

Medicare Enrollment Information

| | |
|---|--|
| Legal Business Name (LBN) | |
| Doing Business As (DBA) | |
| Provider/Supplier Type | |
| National Provider Identifier (NPI) | |
| Provider Transaction Access Number (PTAN) | |
| Changed Information | Include detailed changes or section titles, as applicable. |

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

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

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

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

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

Sincerely,

[Name]
[Title]
[Company]

[CC: RO and State]

B. Approval - Post Tie-In Change of Information (Part A/B Certified)

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor] has processed the Medicare Tie in Notice approving your change of information application.

Medicare Enrollment Information

| | |
|---|--|
| Legal Business Name (LBN) | |
| Doing Business As (DBA) | |
| Provider/Supplier Type | |
| National Provider Identifier (NPI) | |
| Provider Transaction Access Number (PTAN) | |
| Changed Information | Include detailed changes or section titles, as applicable. |

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

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

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

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

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

Sincerely,

[Name]

[Title]

[Company]

C. Approval - Post Tie-In Change of Ownership (Part A/B Certified)

[Month, Day, Year]

[Provider/Supplier Name]

[Address]

[City, State, Zip]

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor] has processed the Medicare Tie in Notice approving your change of ownership application.

Medicare Enrollment Information

| | |
|--|--|
| Legal Business Name (LBN) | |
| Doing Business As (DBA) | |
| Provider/Supplier Type | |
| National Provider Identifier (NPI) | |
| Provider Transaction Access Number (PTAN) | |
| PTAN Effective Date | |
| CHOW Effective Date | |
| Medicare Year-End Cost Report Date (Part A CHOWs only) | |

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

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

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

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

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

Right to Submit a Reconsideration Request:

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

Reconsideration requests must:

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

Providers and suppliers may:

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

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

The reconsideration request should be sent to:

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

Or emailed to:

ProviderEnrollmentAppeals@cms.hhs.gov

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

Sincerely,

[Name]
[Title]
[Company]

D. Approval - Post Tie-In/Initial (Part A/B Certified)

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor] has processed the Medicare Tie in Notice approving your initial enrollment application.

Medicare Enrollment Information

| | |
|--|--|
| Legal Business Name (LBN) | |
| Doing Business As (DBA) | |
| Provider/Supplier Type | |
| National Provider Identifier (NPI) | |
| Provider Transaction Access Number (PTAN) | |
| PTAN Effective Date | |
| Medicare Year-End Cost Report Date (Part A only) | |

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

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

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

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

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

Right to Submit a Reconsideration Request:

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

Reconsideration requests must:

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

Providers and suppliers may:

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

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

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

The reconsideration request should be sent to:

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

Or emailed to:

ProviderEnrollmentAppeals@cms.hhs.gov

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

Sincerely,

[Name]
[Title]
[Company]

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

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor] assessed your initial Medicare enrollment application and forwarded it to the Centers for Medicare & Medicaid Services (CMS) [City] Regional Office for a final review.

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

We will contact you when we have a decision.

Medicare Enrollment Information

| | |
|--|--|
| Legal Business Name (LBN) | |
| Doing Business As (DBA) | |
| Provider/Supplier Type | |
| National Provider Identifier (NPI) | |
| Medicare Year-End Cost Report Date (Part A only) | |

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

Sincerely,

[Name]

[Title]

[Company]

[CC: RO and State]

F. Approval Recommended – Change of Information or Change of Ownership (Part A/B Certified)

[Month, Day, Year]

[Provider/Supplier Name]

[Address]

[City, State, Zip]

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor] assessed your [Change of Information or Change of Ownership] Medicare enrollment application and forwarded it to the Centers for Medicare & Medicaid Services (CMS) [City] Regional Office for a final review.

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

We will contact you when we have a decision.

Medicare Enrollment Information

| | | |
|---|----------------|--|
| Legal Business Name (LBN) | | |
| Doing Business As (DBA) | | |
| Provider/Supplier Type | | |
| National Provider Identifier (NPI) | | |
| Provider Transaction Access Number (PTAN) | | |
| Medicare Year-End Cost Report Date (Part A only) | | |
| Recommended Changes (applicable to COI and CHOW, remove if doesn't apply) | Existing | |
| | New | |
| | Effective Date | |

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

Sincerely,

[Name]

[Title]

[Company]

[CC: RO and State]

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

[Month, Day, Year]

[Provider/Supplier Name]

[Address]

[City, State, Zip]

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor] has [approved your revalidation application/assessed your revalidation application and forwarded it to the Centers for Medicare & Medicaid Services (CMS) [City] Regional Office for a final review].

Medicare Enrollment Information

| | |
|--|--|
| Legal Business Name (LBN) | |
| Doing Business As (DBA) | |
| Provider/Supplier Type | |
| Provider/Supplier National Provider Identifier (NPI) | |
| Provider Transaction Access Number (PTAN) | |
| PTAN Effective Date | |

| | |
|---------------------|--|
| Changed Information | Include detailed changes or section titles, as applicable. |
|---------------------|--|

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

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

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

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

Right to Submit a Reconsideration Request:

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

Reconsideration requests must:

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

Providers and suppliers may:

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

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

The reconsideration request should be sent to:

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

Or emailed to:

ProviderEnrollmentAppeals@cms.hhs.gov

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

Sincerely,

[Name]
[Title]
[Company]

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

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor] completed your application to disenroll from the Medicare program.

Medicare Enrollment Information

| | |
|---|--|
| Legal Business Name (LBN) | |
| Doing Business As (DBA) | |
| Provider/Supplier Type | |
| National Provider Identifier (NPI) | |
| Provider Transaction Access Number (PTAN) | |
| Effective Date of Termination | |

Medicare will not reimburse you for any claims with dates of service on or after your effective date of termination.

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

Sincerely,

[Name]
[Title]
[Company]

[CC: RO and State for Certified Providers]

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

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor] approved your reactivation enrollment application.

Medicare Enrollment Information

| | |
|---------------------------|--|
| Legal Business Name (LBN) | |
|---------------------------|--|

| | |
|---|--|
| Provider/Supplier Type | |
| National Provider Identifier (NPI) | |
| Provider Transaction Access Number (PTAN) | |
| PTAN Effective Date | |
| Participation Status | |

Include if applicable: [While your PTAN(s) and effective date(s) remain the same, you will have a gap in billing privileges from [deactivation date] through [reactivation date] for failing to fully revalidate during a previous revalidation cycle. You will not be reimbursed for services provided to Medicare beneficiaries during this time period since you were not in compliance with Medicare requirements.]

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

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

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

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

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

Right to Submit a Reconsideration Request:

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

Reconsideration requests must:

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.

- If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
- If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.
- Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her behalf.

Providers and suppliers may:

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

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

The reconsideration request should be sent to:

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

Or emailed to:

ProviderEnrollmentAppeals@cms.hhs.gov

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

Sincerely,

[Name]

[Title]
[Company]

10.7.6 – Part B Non-Certified Provider and Supplier Approval Letter Templates

(Rev. 10182; Issued: 06-15-2020; Effective: 09-16-2020; Implementation: 09-16-2020)

A. Approval – Change of Information (Part B Sole Proprietor)

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

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

Medicare Enrollment Information

| | |
|--|--|
| Individual Name | |
| Individual Specialty | |
| Individual National Provider Identifier (NPI) | |
| Individual Provider Transaction Access Number (PTAN) | |
| Changed Information | |

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

You must include your NPI, as the billing and rendering provider, on all Medicare claim submissions.

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

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

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

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

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

Sincerely,

[Name]
[Title]
[Company]

B. Approval – Change of Information (Part B Physician Assistant)

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

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

Medicare Enrollment Information

| | |
|--|---------------------|
| Individual Name | |
| Individual Specialty | Physician Assistant |
| Individual National Provider Identifier (NPI) | |
| Individual Provider Transaction Access Number (PTAN) | |
| Individual PTAN Effective Date | |
| Employer Legal Business Name (LBN) | |
| Employer National Provider Identifier (NPI) | |
| Employer Provider Transaction Access Number (PTAN) | |
| Changed Information | |

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

You must include your NPI, as the rendering provider, on all Medicare claims submissions.

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

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

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

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

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

Sincerely,

[Name]
[Title]
[Company]

C. Approval – Change of Information (Part B Org or Part B Sole Owner)

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

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

Medicare Enrollment Information

| | |
|---------------------------|--|
| Legal Business Name (LBN) | |
|---------------------------|--|

| | |
|---|--|
| Doing Business As (DBA) | |
| Provider/Supplier Type | |
| National Provider Identifier (NPI) | |
| Provider Transaction Access Number (PTAN) | |
| Changed Information | |

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

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

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

Submit updates and changes to your enrollment information within the timeframes specified at [42 CFR §424.516 or 42 CFR§424.205]. For more information on the reporting requirements, go to Medicare Learning Network Article SE1617.

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

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

Sincerely,

[Name]
[Title]
[Company]

D. Approval – Change of Information (Part B Reassignment for Existing Physician or Non-Physician Practitioner)

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

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

Medicare Enrollment Information

| | |
|--|--|
| Individual Name | |
| Individual Specialty | |
| Individual National Provider Identifier (NPI) | |
| Individual Provider Transaction Access Number (PTAN) | |
| Group Legal Business Name (LBN) | |
| Group NPI | |
| Group PTAN | |
| Reassignment Effective Date | |
| Changed Information | |

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

You must include your NPI, as the rendering provider, on all Medicare claim submissions.

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

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

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

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

Sincerely,

[Name]
[Title]
[Company]

E. Approval – Change of Information (Part B Reassignment to CAH)

[Month, Day, Year]

[Provider/Supplier Name]

[Address]
[City, State, Zip]

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

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

Medicare Enrollment Information

| | |
|---|--------------------------------|
| Individual Name | |
| Individual Specialty | |
| Individual National Provider Identifier (NPI) | |
| Provider/Supplier Legal Business Name (LBN) | |
| Provider/Supplier Type | Critical Access Hospital (CAH) |
| Provider/Supplier NPI | |
| Provider/Supplier PTAN | |
| Reassignment Effective Date | |
| Changed Information | |

This action establishes a relationship between the above named individual and the Critical Access Hospital (CAH) facility, in PECOS, for enrollment purposes only. This does not constitute approval of the election of this facility or individual for Method II Billing, as identified in Section 1834(g)(2) of the Act.

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

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

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

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

Sincerely,

[Name]
[Title]
[Company]

F. Approval – Initial/Reactivation Reassignment (Part B CAH)

[Month, Day, Year]

[Provider/Supplier Name]

[Address]

[City, State, Zip]

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor] approved your [initial or reactivation] enrollment application.

Medicare Enrollment Information

| | |
|---|--------------------------------|
| Individual Name | |
| Individual Specialty | |
| Individual National Provider Identifier (NPI) | |
| Provider/Supplier Legal Business Name (LBN) | |
| Provider/Supplier Type | Critical Access Hospital (CAH) |
| Provider/Supplier NPI | |
| Provider/Supplier PTAN | |
| Reassignment Effective Date | |

This action establishes a relationship between the above named individual and the Critical Access Hospital (CAH) facility, in PECOS, for enrollment purposes only. This does not constitute approval of the election of this facility or individual for Method II Billing, as identified in Section 1834(g)(2) of the Act.

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

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

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

Right to Submit a Reconsideration Request:

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

Reconsideration requests must:

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

Providers and suppliers may:

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

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

The reconsideration request should be sent to:

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

Or emailed to:

[Insert MAC email address]

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

Sincerely,

[Name]
[Title]
[Company]

G. Approval – Initial/Reactivation (Part B Order and Certify)

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor] approved your [initial or reactivation] enrollment application to solely order and certify items and services for Medicare beneficiaries. You may not send billed services claims to [Insert Contractor].

Medicare Enrollment Information

| | |
|---|--|
| Individual Name | |
| Individual Specialty | |
| Individual National Provider Identifier (NPI) | |
| Effective Date | |

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

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

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

Right to Submit a Reconsideration Request:

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

Reconsideration requests must:

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

Providers and suppliers may:

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

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

The reconsideration request should be sent to:

[Name of MAC]

[Address]
[City], ST [Zip]

Or emailed to:

[Insert MAC email address]

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

Sincerely,

[Name]
[Title]
[Company]

H. Approval – Change of Information (Part B Order and Certify)

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

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

Medicare Enrollment Information

| | |
|---|--|
| Individual Name | |
| Individual Specialty | |
| Individual National Provider Identifier (NPI) | |
| Changed Information | |

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

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

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

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

Sincerely,

[Name]
[Title]
[Company]

I. Approval – Initial/Reactivation (Part B Org)

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor] approved your [initial or reactivation] enrollment application.

Medicare Enrollment Information

| | |
|---|--|
| Legal Business Name (LBN) | |
| Provider/Supplier Type | |
| National Provider Identifier (NPI) | |
| Provider Transaction Access Number (PTAN) | |
| PTAN Effective Date | |
| Participation Status | |

Include if applicable: [While your PTAN(s) and effective date(s) remain the same, you will have a gap in billing privileges from [deactivation date] through [reactivation date] for failing to fully revalidate during a previous revalidation cycle. You will not be reimbursed for services provided to Medicare beneficiaries during this time period since you were not in compliance with Medicare requirements.]

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

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

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

Submit updates and changes to your enrollment information within the timeframes specified at [42 CFR §424.516 or 42 CFR§424.205]. For more information on the reporting requirements, go to Medicare Learning Network Article SE1617.

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

Right to Submit a Reconsideration Request:

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

Reconsideration requests must:

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

Providers and suppliers may:

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

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

The reconsideration request should be sent to:

(Insert correct address based on whether the MAC or CMS is responsible for handling the reconsideration.

| | | |
|------------------|----|--|
| [Name of MAC] | | [Centers for Medicare & Medicaid Services] |
| [Address] | or | [Provider Enrollment & Oversight Group] |
| [City], ST [Zip] | | [ATTN: Division of Compliance & Appeals] |
| | | [7500 Security Blvd.] |
| | | [Mailstop: AR-19-51] |
| | | [Baltimore, MD 21244-1850] |

Or emailed to:

[Insert MAC email address] or [ProviderEnrollmentAppeals@cms.hhs.gov]

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

Sincerely,

[Name]
[Title]
[Company]

J. Approval – Initial/Reactivation (Part B Physician Assistant)

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor] approved your [initial or reactivation] enrollment application.

Medicare Enrollment Information

| | |
|--|---------------------|
| Individual Name | |
| Individual Specialty | Physician Assistant |
| Individual National Provider Identifier (NPI) | |
| Individual Provider Transaction Access Number (PTAN) | |
| Individual PTAN Effective Date | |
| Employer Legal Business Name (LBN) | |
| Employer National Provider Identifier (NPI) | |
| Employer Provider Transaction Access Number (PTAN) | |

Include if applicable: [While your PTAN(s) and effective date(s) remain the same, you will have a gap in billing privileges from [deactivation date] through [reactivation date] for failing to fully revalidate during a previous revalidation cycle. You will not be reimbursed for services provided to Medicare beneficiaries during this time period since you were not in compliance with Medicare requirements.]

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

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

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

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

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

Right to Submit a Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. (Optional Coversheet

sentence [To facilitate the processing of your reconsideration request, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.])

Reconsideration requests must:

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

Providers and suppliers may:

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

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

The reconsideration request should be sent to:

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

Or emailed to:

[Insert MAC email address]

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

Sincerely,

[Name]

[Title]

[Company]

K. Approval – Initial/Reactivation (Part B Sole Owner)

[Month, Day, Year]

[Provider/Supplier Name]

[Address]

[City, State, Zip]

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor] approved your [initial or reactivation] enrollment application.

Medicare Enrollment Information

| | |
|--|--|
| Individual Name | |
| Individual Specialty | |
| Individual National Provider Identifier (NPI) | |
| Individual Provider Transaction Access Number (PTAN) | |
| Individual PTAN Effective Date | |
| Group Legal Business Name (LBN) | |
| Group Specialty | |
| Group NPI | |
| Group PTAN | |
| Group PTAN Effective Date | |
| Participation Status | |

Include if applicable: [While your PTAN(s) and effective date(s) remain the same, you will have a gap in billing privileges from [deactivation date] through [reactivation date] for failing to fully revalidate during a previous revalidation cycle. You will not be reimbursed for services provided to Medicare beneficiaries during this time period since you were not in compliance with Medicare requirements.]

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

You must include the individual provider's NPI as the rendering provider and the organizational provider's NPI as the billing provider on all Medicare claim submissions.

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

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

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

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

Right to Submit a Reconsideration Request:

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

Reconsideration requests must:

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
 - If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
 - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.

- Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her behalf.

Providers and suppliers may:

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

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

The reconsideration request should be sent to:

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

Or emailed to:

[Insert MAC email address]

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

Sincerely,

[Name]
[Title]
[Company]

L. Approval – Initial/Reactivation (Part B Sole Proprietor)

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor] approved your [initial or reactivation] enrollment application.

Medicare Enrollment Information

| | |
|--|--|
| Individual Name | |
| Individual Specialty | |
| Individual National Provider Identifier (NPI) | |
| Individual Provider Transaction Access Number (PTAN) | |
| PTAN Effective Date | |
| Participation Status | |

Include if applicable: [While your PTAN(s) and effective date(s) remain the same, you will have a gap in billing privileges from [deactivation date] through [reactivation date] for failing to fully revalidate during a previous revalidation cycle. You will not be reimbursed for services provided to Medicare beneficiaries during this time period since you were not in compliance with Medicare requirements.]

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

You must include your NPI, as the billing and rendering provider, on all Medicare claim submissions.

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

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

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

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

Right to Submit a Reconsideration Request:

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

Reconsideration requests must:

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

Providers and suppliers may:

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

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

The reconsideration request should be sent to:

[Name of MAC]
[Address]

[City], ST [Zip]

Or emailed to:

[Insert MAC email address]

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

Sincerely,

[Name]

[Title]

[Company]

M. Approval – Initial/Reactivation with Reassignment (Part B Ind)

[Month, Day, Year]

[Provider/Supplier Name]

[Address]

[City, State, Zip]

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor] approved your [initial or reactivation] enrollment and reassignment application(s).

Medicare Enrollment Information

| | |
|--|--|
| Individual Name | |
| Individual Specialty | |
| Individual National Provider Identifier (NPI) | |
| Individual Provider Transaction Access Number (PTAN) | |
| Group Legal Business Name (LBN) | |
| Group NPI | |
| Group PTAN | |
| Reassignment Effective Date | |

Include if applicable: [While your PTAN(s) and effective date(s) remain the same, you will have a gap in billing privileges from [deactivation date] through [reactivation date] for failing to fully revalidate during a previous revalidation cycle. You will not be reimbursed for services provided to Medicare beneficiaries during this time period since you were not in compliance with Medicare requirements.]

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

You must include your NPI, as the billing and rendering provider, on all Medicare claim submissions.

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

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

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

Right to Submit a Reconsideration Request:

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

Reconsideration requests must:

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

Providers and suppliers may:

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

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

The reconsideration request should be sent to:

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

Or emailed to:

[Insert MAC email address]

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

Sincerely,

[Name]
[Title]
[Company]

N. Approval – Revalidation (Part B Ind with Reassignment)

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor] has approved your revalidation application.

Medicare Enrollment Information

| | |
|--|--|
| Individual Name | |
| Individual Specialty | |
| Individual National Provider Identifier (NPI) | |
| Individual Provider Transaction Access Number (PTAN) | |
| Group Legal Business Name (LBN) | |
| Group NPI | |
| Group PTAN | |
| PTAN Effective Date | |
| Changed Information | |

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

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

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

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

Right to Submit a Reconsideration Request:

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

Reconsideration requests must:

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.

- If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
- If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.
- Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her behalf.

Providers and suppliers may:

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

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

The reconsideration request should be sent to:

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

Or emailed to:

[Insert MAC email address]

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

Sincerely,

[Name]
[Title]
[Company]

O. Approval – Revalidation (Part B Sole Proprietor)

[Month, Day, Year]

[Provider/Supplier Name]

[Address]

[City, State, Zip]

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor] approved your revalidation enrollment application.

Medicare Enrollment Information

| | |
|--|--|
| Individual Name | |
| Individual Specialty | |
| Individual National Provider Identifier (NPI) | |
| Individual Provider Transaction Access Number (PTAN) | |
| PTAN Effective Date | |
| Changed Information | |

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

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

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

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

Right to Submit a Reconsideration Request:

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

Reconsideration requests must:

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

Providers and suppliers may:

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

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

The reconsideration request should be sent to:

[Name of MAC]

[Address]

[City], ST [Zip]

Or emailed to:

[Insert MAC email address]

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

Sincerely,

[Name]

[Title]

[Company]

P. Approval – Revalidation (Part B Physician Assistant)

[Month, Day, Year]

[Provider/Supplier Name]

[Address]

[City, State, Zip]

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor] has approved your revalidation application.

Medicare Enrollment Information

| | |
|--|---------------------|
| Individual Name | |
| Individual Specialty | Physician Assistant |
| Individual National Provider Identifier (NPI) | |
| Individual Provider Transaction Access Number (PTAN) | |
| Individual PTAN Effective Date | |
| Employer Legal Business Name (LBN) | |
| Employer National Provider Identifier (NPI) | |
| Employer Provider Transaction Access Number (PTAN) | |
| Changed Information | |

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

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

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

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

Right to Submit a Reconsideration Request:

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

Reconsideration requests must:

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

Providers and suppliers may:

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

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

The reconsideration request should be sent to:

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

Or emailed to:

[Insert MAC email address]

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

Sincerely,

[Name]
[Title]
[Company]

Q. Approval – Revalidation (Part B Non-Certified Org or Part B Sole Owner)

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor] has approved your revalidation application.

Medicare Enrollment Information

| | |
|--|--|
| Legal Business Name (LBN) | |
| Doing Business As (DBA) | |
| Provider/Supplier Type | |
| Provider/Supplier National Provider Identifier (NPI) | |
| Provider Transaction Access Number (PTAN) | |
| PTAN Effective Date | |
| Changed Information | |

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

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

Submit updates and changes to your enrollment information within the timeframes specified at [42 CFR §424.516 or 42 CFR§424.205]. For more information on the reporting requirements, go to Medicare Learning Network Article SE1617.

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

Right to Submit a Reconsideration Request:

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

Reconsideration requests must:

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

Providers and suppliers may:

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

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

The reconsideration request should be sent to:

(Insert correct address based on whether the MAC or CMS is responsible for handling the reconsideration.

| | | |
|------------------|----|--|
| [Name of MAC] | | [Centers for Medicare & Medicaid Services] |
| [Address] | or | [Provider Enrollment & Oversight Group] |
| [City], ST [Zip] | | [ATTN: Division of Compliance & Appeals] |
| | | [7500 Security Blvd.] |
| | | [Mailstop: AR-19-51] |
| | | [Baltimore, MD 21244-1850] |

Or emailed to:

[Insert MAC email address] or [ProviderEnrollmentAppeals@cms.hhs.gov]

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

Sincerely,

[Name]
[Title]
[Company]

R. Approval – Voluntary Termination (Part B Sole Proprietor)

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor] completed your application to disenroll from the Medicare program.

Medicare Enrollment Information

| | |
|--|--|
| Individual Name | |
| Individual Specialty | |
| Individual National Provider Identifier (NPI) | |
| Individual Provider Transaction Access Number (PTAN) | |
| Effective Date of Termination | |

Medicare will not reimburse you for any claims with dates of service on or after your effective date of termination.

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

Sincerely,

[Name]
[Title]
[Company]

S. Approval – Voluntary Termination (Part B Physician Assistant)

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor] completed your application to disenroll from the Medicare program.

Medicare Enrollment Information

| | |
|-----------------|--|
| Individual Name | |
|-----------------|--|

| | |
|--|---------------------|
| Individual Specialty | Physician Assistant |
| Individual National Provider Identifier (NPI) | |
| Individual Provider Transaction Access Number (PTAN) | |
| Employer Name | |
| Employer National Provider Identifier (NPI) | |
| Employer Provider Transaction Access Number (PTAN) | |
| Effective Date of Termination | |

Medicare will not reimburse you for any claims with dates of service on or after your effective date of termination.

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

Sincerely,

[Name]

[Title]

[Company]

T. Approval – Termination of Reassignment (Part B Ind)

[Month, Day, Year]

[Provider/Supplier Name]

[Address]

[City] ST [Zip]

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor] completed your application to disenroll from the Medicare program.

Medicare Enrollment Information

| | |
|--|--|
| Individual Name | |
| Individual Specialty | |
| Individual National Provider Identifier (NPI) | |
| Individual Provider Transaction Access Number (PTAN) | |
| Group Name | |
| Group National Provider Identifier (NPI) | |

| | |
|---|--|
| Group Provider Transaction Access Number (PTAN) | |
| Effective Date of Termination | |

Medicare will not reimburse you for any claims with dates of service on or after your effective date of termination.

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

Sincerely,

[Name]
[Title]
[Company]

U. Approval – Termination of Reassignment (Part B CAH)

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor] completed your application to disenroll from the Medicare program.

Medicare Enrollment Information

| | |
|---|--------------------------------|
| Individual Name | |
| Individual Specialty | |
| Individual National Provider Identifier (NPI) | |
| Provider/Supplier Legal Business Name (LBN) | |
| Provider/Supplier Type | Critical Access Hospital (CAH) |
| Provider/Supplier NPI | |
| Provider/Supplier PTAN | |
| Effective Date of Termination | |

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

Sincerely,

[Name]
[Title]
[Company]

V. Approval – Voluntary Termination (Part B Non-Certified Org or Part B Sole Owner)

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor] completed your application to disenroll from the Medicare program.

Medicare Enrollment Information

| | |
|---|--|
| Legal Business Name (LBN) | |
| Doing Business As (DBA) | |
| Provider/Supplier Type | |
| National Provider Identifier (NPI) | |
| Provider Transaction Access Number (PTAN) | |
| Effective Date of Termination | |

Reassignments and any physician assistant employment arrangements are also deactivated.

Medicare will not reimburse you for any claims with dates of service on or after your effective date of termination.

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

Sincerely,

[Name]
[Title]
[Company]

10.7.7 – Application Return and Rejection Model Letters
(Rev. 10611; Issued: 03-19-21; Effective:11-19-20; Implementation: 11-19-20)

A. Returned Application Letter

[month] [day], [year]

[Provider/Supplier Name]

[Address]

[City] ST [Zip]

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

Dear [Provider/Supplier Name]:

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

[List all reasons for return]

If you would like to resubmit an application, you must complete a new Medicare enrollment application(s). Please address the above issues as well as sign and date the new certification statement page on your resubmitted application(s).

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

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

Please return the completed application(s) to:

[Name of MAC]

[Address]

[City], ST [Zip]

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

Sincerely,

[Name]
[Title]
[Company]

B. Model Rejection Letter

[month] [day], [year]

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

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

Dear [Provider/Supplier Name]:

We received your Medicare enrollment application(s) on [Receipt Date].
We are rejecting your application(s) for the following reason(s):

[List all reasons for rejection]

If you would like to resubmit an application, you must complete a new Medicare enrollment application(s). Please address the above issues as well as sign and date the new certification statement page on your resubmitted application(s).

In compliance with Federal regulations found at 42 CFR §424.525, providers and suppliers are required to submit complete application(s) and all supporting documentation within 30 calendar days from the postmark date of the contractor request for missing/incomplete information.

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

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

Please return the completed application(s) to:

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

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

Sincerely,

[Name]
[Title]
[Company]

C. Rejection Letter for Locations That Do Not Meet the Distance Requirements

C

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

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

Dear [Provider/Supplier Name]:

We received your Medicare enrollment application(s) to add a new provider-based location to your Critical Access Hospital enrollment on [date]. We are rejecting your application because the CMS Regional Office, Division of Survey and Certification (RO DSC) has found that your new location does not meet distance requirements found in 42 CFR 485.610(e)(2).

Please refer to communications from the RO DSC for instructions for your next steps regarding the new provider-based location.

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

Sincerely,

[Name]
[Title]

[Company]

10.7.8 – Denial Model Letters

(Rev. 10611; Issued: 03-19-21; Effective:11-19-20; Implementation: 11-19-20)

A. Denial Letter Guidance

The contractor must submit one or more of 14 primary denial citations as found in Section 10.4(H)(3) of this chapter into the appropriate section on the Model Denial Letter. Only the CFR citation and a short heading shall be cited for the primary denial reason.

- The contractor may submit one or more denial reason, as appropriate. The denial reason(s) should state sufficient details so it is clear as to why the provider or supplier is being denied.
- Specific Denial Reasons may contain one or more of the following items:
 - A specific regulatory (CFR) citation.
 - Dates (of actions, suspensions, convictions, receipt of documents, etc.)
 - Pertinent details of action(s)

National Supplier Clearinghouse (NSC) only language. All denial letters for the NSC shall replace the 1st paragraph of the model denial letter with the following text:

Your application to enroll in Medicare is denied. After reviewing your submitted application document(s), it was determined that per 42 CFR §405.800, 42 CFR §424.57, and 42 CFR §498.22, that you do not meet the conditions of enrollment or meet the requirements to qualify as a Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) provider or supplier for the following reason(s):

Exclusions and sanctions – the following two sentences should be REMOVED for all denial letters that DO NOT involve an exclusion or sanction action:

You may not appeal through this process the merits of any exclusion by another federal agency. Any further permissible administrative

appeal involving the merits of such exclusion must be filed with the federal agency that took the action.

For IDTF, DMEPOS, and MDPP providers and suppliers, each regulatory citation needs to be listed along with the specific regulatory language. For IDTF, the standards are found in 42 CFR §410.33(g) 1 through 17. For DMEPOS providers and suppliers, the standards are found in 42 CFR §424.57(c) 1 through 30. For MDPP suppliers, the standards are found in 42 CFR §424.205(d).

If a provider is being added to the CMS Preclusion List, the following should be inserted to the denial letter (should PEOG instruct the contractor to do so:

The Centers for Medicare & Medicaid Services (CMS) has been made aware of [Provider Name]'s [Date], felony conviction, as defined in 42 C.F.R. § 1001.2, for [reason] in violation of [Code] in the Court Name]. After reviewing the specific facts and circumstances surrounding [Jane Doe]'s felony conviction, CMS has determined that [Provider Name]'s felony conviction is detrimental to the best interests of the Medicare program and its beneficiaries.

Additionally, [Provider Name] will be placed on the CMS Preclusion List because [he/she] has been convicted of a felony, as described above, under Federal or State law, within the previous 10 years, that CMS deems detrimental to the best interests of the Medicare program. CMS may take this action regardless of whether you are or were enrolled in the Medicare program. This action is being taken pursuant to 42 C.F.R. §§ 422.2, 422.222, 423.100, and 423.120(c)(6).

The effective date of your inclusion on the Preclusion List is dependent upon the submission or non-submission of a reconsideration request (see below). If you do submit a reconsideration request and your inclusion on the Preclusion List is upheld, you will be added to the Preclusion List on the date of the reconsideration decision. If you do not submit a reconsideration request, you will be included on the Preclusion List 65 days after the date of this letter.

During the time period that your name will be included on the Preclusion List as listed above, any claims you submit for health care items or services furnished under a Medicare Advantage (MA) benefit may be denied. Additionally, any pharmacy claims submitted for Medicare Part D drugs that you prescribe may be rejected or denied. This means that your patients may not be able to receive coverage of their prescriptions using their Part D benefit at the pharmacy.

The below appeal rights apply to both your denial and preclusion. If you choose to appeal, you **must** file an appeal to the denial and preclusion jointly.

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination.

Reconsideration requests must:

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

Providers and suppliers may:

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

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

The reconsideration request should be sent to:

Centers for Medicare & Medicaid Services
Provider Enrollment & Oversight Group
Attn: Division of Compliance and Appeals
7500 Security Boulevard
Mailstop AR-18-50
Baltimore, MD 21244-1850

Or emailed to:

ProviderEnrollmentAppeals@cms.hhs.gov

B. Model Denial Letter

[month] [day], [year]

[Provider/Supplier Name]

[Address]

[City] ST [Zip]

Reference # (Contractor Control Number or NPI)

Dear [Provider/Supplier Name]:

Your application to enroll in Medicare is denied for the following reason(s):

xx CFR §xxx.(x) [heading]

[Specific reason]

xx CFR §xxx.(x) [heading]

[Specific reason]

Right to Submit a Corrective Action Plan (CAP) and Reconsideration Request:

Corrective Action Plan: (Only if denied under 42 C.F.R. § 424.530(a)(1))

You may submit a corrective action plan (CAP) in response to the denial of an enrollment application under 42 C.F.R. § 424.530(a)(1). You may also request a reconsideration (described below). If your enrollment

application was denied under authorities other than 42 C.F.R. § 424.530(a)(1), you may **only** submit a reconsideration request in response to those denial bases.

The CAP is an opportunity to demonstrate that you have corrected the deficiencies identified above and thereby, establish your eligibility to enroll in the Medicare program. (Optional Coversheet sentence: [To facilitate the processing of your CAP, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.]) The CAP must:

- Be received in writing within 35 calendar days of the date of this letter and mailed to the address below or emailed to the address below;
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
 - If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
 - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.
 - Authorized or delegated officials for groups cannot sign and submit a CAP on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her behalf.
- Provide evidence to demonstrate that you are in compliance with Medicare requirements.

Please note that CAPs may not be appealed further to the Departmental Appeals Board. Further appeal rights do exist for reconsideration requests (described below). CAP requests should be sent to:

(Insert correct address based on whether the MAC or CMS is responsible for reviewing the CAP)

[Name of MAC]

[Address]

[City], ST [Zip]

o

r

Centers for Medicare & Medicaid

Services

Center for Program Integrity

Provider Enrollment & Oversight Group

Attn: Division of Compliance and Appeals

7500 Security Boulevard

Mailstop AR-18-50

Or emailed to:

[Insert MAC email address]or
[ProviderEnrollmentAppeals@cms.hhs.gov]

Reconsideration Request:

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

Reconsideration requests must:

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

Providers and suppliers may:

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

information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.

- Include an email address if you want to receive correspondence regarding your appeal via email.
- (If denied under 42 C.F.R. § 424.530(a)(2)) Please note that you may not appeal through this process the merits of any exclusion by another Federal agency. Any further permissible administrative appeal involving the merits of such exclusion must be filed with the Federal agency that took the action.

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

The reconsideration request should be sent to:

(Insert correct address based on whether the MAC or CMS is responsible for handling the reconsideration.

| | | |
|------------------|---|--|
| [Name of MAC] | | Centers for Medicare & Medicaid |
| [Address] | o | Services |
| [City], ST [Zip] | r | Center for Program Integrity |
| | | Provider Enrollment & Oversight Group |
| | | Attn: Division of Compliance and Appeals |
| | | 7500 Security Boulevard |
| | | Mailstop AR-18-50 |
| | | Baltimore, MD 21244-1850 |

Or emailed to:

[Insert MAC email address]or
[ProviderEnrollmentAppeals@cms.hhs.gov]

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

Sincerely,

[Name]
[Title]
[Company]

C. Denial Example Letters

Note that each example contains appeal rights for both CMS and the MAC, regardless of the example reason, so that the contractors may

include the appropriate appeal address based on the provider or supplier type that has been denied.

1. Discipline Not Eligible Example

[month] [day], [year]

[Provider/Supplier Name]

[Address]

[City] ST [Zip]

Reference # (Contractor Control Number or NPI)

Dear [Provider/Supplier Name]:

Your application to enroll in Medicare is denied for the following reason(s):

42 CFR §424.530(a)(1) – Not in Compliance with Medicare Requirements

There is no statutory or regulatory basis which permits a Marriage and Family Therapist to enroll or receive payment in the Medicare Program.

Right to Submit a Corrective Action Plan (CAP) and Reconsideration Request:

Corrective Action Plan: (Only if denied under 42 C.F.R. § 424.530(a)(1))

You may submit a corrective action plan (CAP) in response to the denial of an enrollment application under 42 C.F.R. § 424.530(a)(1). You may also request a reconsideration (described below). If your enrollment application was denied under authorities other than 42 C.F.R. § 424.530(a)(1), you may **only** submit a reconsideration request in response to those denial bases.

The CAP is an opportunity to demonstrate that you have corrected the deficiencies identified above and thereby, establish your eligibility to enroll in the Medicare program. (Optional Coversheet sentence: [To facilitate the processing of your CAP, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.]) The CAP must:

- Be received in writing within 35 calendar days of the date of this letter and mailed to the address below or emailed to the address

below;

- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
 - If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
 - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.
 - Authorized or delegated officials for groups cannot sign and submit a CAP on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her behalf.
- Provide evidence to demonstrate that you are in compliance with Medicare requirements.

Please note that CAPs may not be appealed further to the Departmental Appeals Board. Further appeal rights do exist for reconsideration requests (described below). CAP requests should be sent to:

(Insert correct address based on whether the MAC or CMS is responsible for reviewing the CAP)

| | | |
|------------------|---|--|
| [Name of MAC] | | Centers for Medicare & Medicaid |
| [Address] | o | Services |
| [City], ST [Zip] | r | Center for Program Integrity |
| | | Provider Enrollment & Oversight Group |
| | | Attn: Division of Compliance and Appeals |
| | | 7500 Security Boulevard |
| | | Mailstop AR-18-50 |
| | | Baltimore, MD 21244-1850 |

Or emailed to:

[Insert MAC email address]or
[ProviderEnrollmentAppeals@cms.hhs.gov]

Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial

determination. (Optional Coversheet sentence [To facilitate the processing of your reconsideration request, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.]])

Reconsideration requests must:

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

Providers and suppliers may:

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.
- Include an email address if you want to receive correspondence regarding your appeal via email.
- (If denied under 42 C.F.R. § 424.530(a)(2)) Please note that you may not appeal through this process the merits of any exclusion by another Federal agency. Any further permissible administrative appeal involving the merits of such exclusion must be filed with

the Federal agency that took the action.

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

The reconsideration request should be sent to:

(Insert correct address based on whether the MAC or CMS is responsible for handling the reconsideration.

| | | |
|------------------|---|--|
| [Name of MAC] | | Centers for Medicare & Medicaid |
| [Address] | o | Services |
| [City], ST [Zip] | r | Center for Program Integrity |
| | | Provider Enrollment & Oversight Group |
| | | Attn: Division of Compliance and Appeals |
| | | 7500 Security Boulevard |
| | | Mailstop AR-18-50 |
| | | Baltimore, MD 21244-1850 |

Or emailed to:

[Insert MAC email address]or
[ProviderEnrollmentAppeals@cms.hhs.gov]

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

Sincerely,
[Name]

[Title]
[Company]

2. Criteria for Eligible Discipline Not Met Example

[month] [day], [year]

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

Reference # (Contractor Control Number or NPI)

Dear [Provider/Supplier Name]:

Your application to enroll in Medicare is denied for the following reason(s):

42 CFR §424.530(a)(1) - Not in Compliance with Medicare Requirements

Per 42 CFR §410.75(b)(1)(i), the provider or supplier is not certified by a recognized national certifying body that has established standards for nurse practitioners.

Right to Submit a Corrective Action Plan (CAP) and Reconsideration Request:

Corrective Action Plan: (Only if denied under 42 C.F.R. § 424.530(a)(1))

You may submit a corrective action plan (CAP) in response to the denial of an enrollment application under 42 C.F.R. § 424.530(a)(1). You may also request a reconsideration (described below). If your enrollment application was denied under authorities other than 42 C.F.R. § 424.530(a)(1), you may **only** submit a reconsideration request in response to those denial bases.

The CAP is an opportunity to demonstrate that you have corrected the deficiencies identified above and thereby, establish your eligibility to enroll in the Medicare program. (Optional Coversheet sentence: [To facilitate the processing of your CAP, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.]) The CAP must:

- Be received in writing within 35 calendar days of the date of this letter and mailed to the address below or emailed to the address below;
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
 - If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
 - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.
 - Authorized or delegated officials for groups cannot sign

and submit a CAP on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her behalf.

- Provide evidence to demonstrate that you are in compliance with Medicare requirements.

Please note that CAPs may not be appealed further to the Departmental Appeals Board. Further appeal rights do exist for reconsideration requests (described below). CAP requests should be sent to:

(Insert correct address based on whether the MAC or CMS is responsible for reviewing the CAP)

| | | |
|------------------|---|--|
| [Name of MAC] | | Centers for Medicare & Medicaid |
| [Address] | o | Services |
| [City], ST [Zip] | r | Center for Program Integrity |
| | | Provider Enrollment & Oversight Group |
| | | Attn: Division of Compliance and Appeals |
| | | 7500 Security Boulevard |
| | | Mailstop AR-18-50 |
| | | Baltimore, MD 21244-1850 |

Or emailed to:

[Insert MAC email address]or
[ProviderEnrollmentAppeals@cms.hhs.gov]

Reconsideration Request:

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

Reconsideration requests must:

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.

- If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
- If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.
- Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her behalf.

Providers and suppliers may:

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.
- Include an email address if you want to receive correspondence regarding your appeal via email.
- (If denied under 42 C.F.R. § 424.530(a)(2)) Please note that you may not appeal through this process the merits of any exclusion by another Federal agency. Any further permissible administrative appeal involving the merits of such exclusion must be filed with the Federal agency that took the action.

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

The reconsideration request should be sent to:

(Insert correct address based on whether the MAC or CMS is responsible for handling the reconsideration.

| | | |
|------------------|---|--|
| [Name of MAC] | | Centers for Medicare & Medicaid |
| [Address] | o | Services |
| [City], ST [Zip] | r | Center for Program Integrity |
| | | Provider Enrollment & Oversight Group |
| | | Attn: Division of Compliance and Appeals |

7500 Security Boulevard
Mailstop AR-18-50
Baltimore, MD 21244-1850

Or emailed to:

[Insert MAC email address]or
[ProviderEnrollmentAppeals@cms.hhs.gov]

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

Sincerely,
[Name]

[Title]
[Company]

3. Provider Standards Not Met Example

[month] [day], [year]

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

Reference # (Contractor Control Number or NPI)

Dear IDTF Services, Inc.:

Your application to enroll in Medicare is denied for the following
reason(s):

42 CFR §424.530(a)(5) - On-site Review - Requirements Not Met
Specifically, the following standards were not met:

42 CFR §410.33(g) 4 - Have all applicable diagnostic testing
equipment available at the physical site excluding portable diagnostic
testing equipment. A catalog of portable diagnostic equipment,
including diagnostic testing equipment serial numbers, must be
maintained at the physical site. In addition, portable diagnostic testing
equipment must be available for inspection within two business days
of a CMS inspection request. The IDTF must maintain a current
inventory of the diagnostic testing equipment, including serial and
registration numbers, provide this information to the designated fee-
for-service contractor upon request, and notify the contractor of any
changes in equipment within 90 days.

42 CFR §410.33(g) 9 - Openly post these [IDTF] standards for review by patients and the public

42 CFR §410.33(g) 11 - Have its testing equipment calibrated and maintained per equipment instructions and in compliance with applicable manufacturers suggested maintenance and calibration standards.

42 CFR §410.33(g) 12 - Have technical staff on duty with the appropriate credentials to perform tests. The IDTF must be able to produce the applicable Federal or State licenses or certifications of the individuals performing these services.

Right to Submit a Corrective Action Plan (CAP) and Reconsideration Request:

Corrective Action Plan: (Only if denied under 42 C.F.R. § 424.530(a)(1))

You may submit a corrective action plan (CAP) in response to the denial of an enrollment application under 42 C.F.R. § 424.530(a)(1). You may also request a reconsideration (described below). If your enrollment application was denied under authorities other than 42 C.F.R. § 424.530(a)(1), you may **only** submit a reconsideration request in response to those denial bases.

The CAP is an opportunity to demonstrate that you have corrected the deficiencies identified above and thereby, establish your eligibility to enroll in the Medicare program. (Optional Coversheet sentence: [To facilitate the processing of your CAP, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.]) The CAP must:

- Be received in writing within 35 calendar days of the date of this letter and mailed to the address below or emailed to the address below;
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
 - If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
 - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated

official must file written notice of the appointment of its representative with the submission of the reconsideration request.

- Authorized or delegated officials for groups cannot sign and submit a CAP on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her behalf.
- Provide evidence to demonstrate that you are in compliance with Medicare requirements.

Please note that CAPs may not be appealed further to the Departmental Appeals Board. Further appeal rights do exist for reconsideration requests (described below). CAP requests should be sent to:

(Insert correct address based on whether the MAC or CMS is responsible for reviewing the CAP)

| | | |
|------------------|---|--|
| [Name of MAC] | | Centers for Medicare & Medicaid |
| [Address] | o | Services |
| [City], ST [Zip] | r | Center for Program Integrity |
| | | Provider Enrollment & Oversight Group |
| | | Attn: Division of Compliance and Appeals |
| | | 7500 Security Boulevard |
| | | Mailstop AR-18-50 |
| | | Baltimore, MD 21244-1850 |

Or emailed to:

[Insert MAC email address]or
[ProviderEnrollmentAppeals@cms.hhs.gov]

Reconsideration Request:

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

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- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.
- Include an email address if you want to receive correspondence regarding your appeal via email.
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If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

(Insert correct address based on whether the MAC or CMS is responsible for handling the reconsideration.

42 CFR §424.530(a)(1) - Not in Compliance with Medicare Requirements

42 CFR §410.62(c)(ii) states that speech language pathologists in private practice must be engaged in one of the following practice types if allowed by State and local law: (A) An unincorporated solo practice; (B) An unincorporated partnership or unincorporated group practice; (C) An employee in an unincorporated solo practice, partnership, or group practice, or a professional corporation or other incorporated speech-language pathology practice; (D) An employee of a physician group (includes certain Non-Physician Practitioners

[NPPs], as appropriate); or (E) An employee of a group that is not a professional corporation.

Your current private practice status is an incorporated solo practice; therefore, you do not qualify as a Medicare provider or supplier.

Right to Submit a Corrective Action Plan (CAP) and Reconsideration Request:

Corrective Action Plan: (Only if denied under 42 C.F.R. § 424.530(a)(1))

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 - Authorized or delegated officials for groups cannot sign and submit a CAP on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the

group to act on his/her behalf.

- Provide evidence to demonstrate that you are in compliance with Medicare requirements.

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| | | 7500 Security Boulevard |
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Or emailed to:

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Providers and suppliers may:

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Or emailed to:

[Insert MAC email address]or
[ProviderEnrollmentAppeals@cms.hhs.gov]

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

Sincerely,
[Name]

[Title]
[Company]

5. Existing or Delinquent Overpayments Example

[month] [day], [year]

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

Reference # (Contractor Control Number or NPI)

Dear [Provider/Supplier Name]:

Your application to enroll in Medicare is denied for the following reason(s):

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.

Dates: (enter date of existing or delinquent overpayment period)

Pertinent details of action(s) (Whether the person or entity is on a Medicare-approved plan of repayment of payments are currently being offset: Whether the overpayment is currently being appealed; the reason for the overpayment)

**Right to Submit a Corrective Action Plan (CAP) and
Reconsideration Request:**

Corrective Action Plan: (Only if denied under 42 C.F.R. § 424.530(a)(1))

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- Provide evidence to demonstrate that you are in compliance with Medicare requirements.

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(Insert correct address based on whether the MAC or CMS is responsible for reviewing the CAP)

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

o
r

Centers for Medicare & Medicaid
Services
Center for Program Integrity
Provider Enrollment & Oversight Group
Attn: Division of Compliance and Appeals
7500 Security Boulevard
Mailstop AR-18-50
Baltimore, MD 21244-1850

Or emailed to:

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Reconsideration Request:

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

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Or emailed to:

[Insert MAC email address]or
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If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,
[Name]

[Title]
[Company]

6. MDPP Supplier Standards Not Met – Ineligible Coach Example

[month] [day], [year]

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

Reference # (Contractor Control Number or NPI)

Dear [Provider/Supplier Name]:

Your application to enroll in Medicare is denied for the following reason(s):

42 CFR §424.530(a)(1) - Not in Compliance with Medicare Requirements

Specifically, the following standards were not met:

42 CFR §424.205(d)(3) - The MDPP supplier must not include on the roster of coaches nor permit MDPP services to be furnished by any individual coach who meets any of ineligibility criteria.

42 CFR §424.205(e)(v)(a) specifies that an individual with a state or federal felony conviction in the previous 10 years of any crime against persons, such as murder, rape, assault, and other similar crimes, would not meet the eligibility criteria to be an MDPP coach.

The following coach included on Section 7 of your Form CMS-20134 or its electronic equivalent meets this ineligibility criteria:

John B. Doe | DOB: June 19, 1991 | NPI: 1234567

Please see attached documentation of the felony conviction.

Right to Submit a Corrective Action Plan (CAP) and Reconsideration Request:

Corrective Action Plan: (Only if denied under 42 C.F.R. § 424.530(a)(1))

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[Name of MAC]
[Address]

o

Centers for Medicare & Medicaid
Services

[City], ST [Zip] r

Center for Program Integrity
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If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,
 [Name]

[Title]
[Company]

10.7.9 – Revocation Letters

(Rev. 10611; Issued: 03-19-21; Effective:11-19-20; Implementation: 11-19-20)

A. Revocation Letter Guidance

The contractor:

- Must submit one or more of the Primary Revocation Reasons as found in section 10.4(M)(2) into the appropriate section on the specific Revocation Letter. Only the CFR citation and a short heading shall be cited for the primary revocation reason.
- Shall include sufficient details to support the reason for the provider or supplier's revocation;
- Shall issue all revocation letters via certified letter, per regulations found in 42 CFR 405.800(b)(1), and;
- Shall issue two revocation letters to any solely owned organizations, one for the individual and the other for the organization.

B. Model Revocation Letters

1. Revocation Example - Letter for National Supplier Clearinghouse (NSC)

[month] [day], [year]

[Supplier Name]

[Address]

[City] ST [Zip]

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

number: [number]

Returned receipt requested

Dear [Supplier Name]:

The purpose of this letter is to inform you that pursuant to 42 CFR §§ 405.800, 424.57(x), 424.535(g), and 424.535(a)[(x)], your Medicare

supplier number [xxxxxxxxxx] for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) issued by the National Supplier Clearinghouse (NSC)

[will be revoked effective 30 days from the postmarked date of this letter]

[is revoked. The effective date of this revocation has been made retroactive to [month] [day], [year], which is the date [revocation reason]]

Pursuant to 42 CFR §424.535(c), the supplier is barred from re-enrolling for a period of [number of years] year(s) in the Medicare program from the effective date of the revocation. In order to re-enroll, you must meet all requirements for your supplier type.

[The Supplier Audit and Compliance Unit (SACU) reviewed and evaluated the documents you submitted in response to the developmental letter dated [date]. This letter allowed you to demonstrate your full compliance with the DMEPOS supplier standards and/or to correct the deficient compliance requirement(s).]

[The Supplier Audit and Compliance Unit (SACU) has not received a response to the developmental letter sent to you on [date]. This letter allowed you to demonstrate your full compliance with the DMEPOS supplier standards and/or to correct the deficient compliance requirement(s)]

[The National Supplier Clearinghouse has not received a response to the developmental letter sent to you on [date] informing you that the request for a hardship exception for the required application fee was denied. The notification afforded you the opportunity to pay the mandatory application fee for processing your enrollment application and an appeal period which you did not select.]

[The National Supplier Clearinghouse has not received a response to the developmental letter sent to you on [date] informing you that the application fee was not paid at the time you filed the CMS 855S enrollment application. The 30day notification afforded you the opportunity to pay the mandatory application fee for processing your enrollment application]

We have determined that you are not in compliance with the supplier standards noted below:

42 CFR §424.579(c) [1-30] [Insert the specific performance standard not met]

Section 1834(j) of the Social Security Act states that, with the exception of medical equipment and supplies furnished incident to a physician's service, no payment may be made by Medicare for items furnished by a supplier unless the supplier has a valid Medicare billing number. Therefore, any expenses for items you supply to a Medicare beneficiary on or after the effective date of the revocation of your billing numbers are your responsibility and not the beneficiary's, unless you have proof that you have notified the beneficiary in accordance with section 1834 (a)(A)(ii) of the Social Security Act and the beneficiary has agreed to take financial responsibility if the items you supply are not covered by Medicare. You will be required to refund on a timely basis to the beneficiary (and will be liable to the beneficiary for) any amounts collected from the beneficiary for such items. If you fail to refund the beneficiary as required under 1834 (j) (4) and 1879(h) of the Social Security Act, you may be liable for Civil Monetary penalties.

You may not appeal through this process the merits of any exclusion by another Federal agency. Any further permissible administrative appeal involving the merits of such exclusion must be filed with the Federal agency that took the action.

Right to Submit a Corrective Action Plan (CAP) and Reconsideration Request:

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- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.
- Include an email address if you want to receive correspondence regarding your appeal via email.
- (If denied under 42 C.F.R. § 424.530(a)(2)) Please note that you may not appeal through this process the merits of any exclusion by another Federal agency. Any further permissible administrative appeal involving the merits of such exclusion must be filed with the Federal agency that took the action.

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

The reconsideration request should be sent to:

(Insert correct address based on whether the MAC or CMS is responsible for handling the reconsideration.

| | | |
|------------------|---|--|
| [Name of MAC] | | Centers for Medicare & Medicaid |
| [Address] | o | Services |
| [City], ST [Zip] | r | Center for Program Integrity |
| | | Provider Enrollment & Oversight Group |
| | | Attn: Division of Compliance and Appeals |
| | | 7500 Security Boulevard |
| | | Mailstop AR-18-50 |
| | | Baltimore, MD 21244-1850 |

Or emailed to:

[Insert MAC email address]or
[ProviderEnrollmentAppeals@cms.hhs.gov]

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

Sincerely,

[Name]
[Title]
[Company]

2. Model Revocation Letter for Part B Suppliers and Certified Providers and Suppliers

[Month] [day], [year]

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

Reference # (Contractor Control Number or NPI)

Dear [Provider/Supplier Name]:

Your Medicare privileges are being revoked effective [Date of revocation] for the following reasons:

xx CFR §xxx.(x) [heading]
[Specific reason]

xx CFR §xxx.(x) [heading]
[Specific reason]

(For certified providers and certified suppliers only: Pursuant to 42 CFR §424.535(b), this action will also terminate your corresponding (provider or supplier) agreement.)

Right to Submit a Corrective Action Plan (CAP) and Reconsideration Request:

Corrective Action Plan: (Only if revoked under 42 C.F.R. § 424.535(a)(1))

You may submit a corrective action plan (CAP) in response to the revocation of Medicare billing privileges under 42 C.F.R. § 424.535(a)(1). You may also request a reconsideration (described below). If your Medicare billing privileges were revoked under authorities other than 42 C.F.R. § 424.535(a)(1), you may **only** submit a reconsideration request in response to those revocation bases.

The CAP is an opportunity to demonstrate that you have corrected the deficiencies identified above and thereby, establish your eligibility to maintain enrollment in the Medicare program. (Optional Coversheet sentence [To facilitate the processing of your CAP, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.]) The CAP must:

- Be received in writing within 35 calendar days of the date of this letter and mailed or emailed to the address below;
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
 - If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
 - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.

- Authorized or delegated officials for groups cannot sign and submit a CAP on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her behalf.
- Provide evidence to demonstrate that you are in compliance with Medicare requirements.

(Insert correct address based on whether the MAC or CMS is responsible for reviewing the CAP)

The CAP should be sent to:

| | | |
|------------------|---|--|
| [Name of MAC] | | Centers for Medicare & Medicaid |
| [Address] | o | Services |
| [City], ST [Zip] | r | Center for Program Integrity |
| | | Provider Enrollment & Oversight Group |
| | | Attn: Division of Compliance and Appeals |
| | | 7500 Security Boulevard |
| | | Mailstop AR-18-50 |
| | | Baltimore, MD 21244-1850 |

Or emailed to:

[Insert MAC email address]or
 [ProviderEnrollmentAppeals@cms.hhs.gov]

Reconsideration Request:

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

Reconsideration requests must:

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
 - If the authorized representative is an attorney, the

attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.

- If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.
- Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her behalf.

Providers and suppliers may:

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.
- Include an email address if you want to receive correspondence regarding your appeal via email.
- (If revoked under 42 C.F.R. § 424.535(a)(2)) Please note that you may not appeal through this process the merits of any exclusion by another Federal agency. Any further permissible administrative appeal involving the merits of such exclusion must be filed with the Federal agency that took the action.

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

The reconsideration request should be sent to:

(Insert correct address based on whether the MAC or CMS is responsible for handling the reconsideration.

| | | |
|------------------|---|---------------------------------------|
| [Name of MAC] | | Centers for Medicare & Medicaid |
| [Address] | o | Services |
| [City], ST [Zip] | r | Center for Program Integrity |
| | | Provider Enrollment & Oversight Group |

Attn: Division of Compliance and Appeals
7500 Security Boulevard
Mailstop AR-18-50
Baltimore, MD 21244-1850

Or emailed to:

[Insert MAC email address]or
[ProviderEnrollmentAppeals@cms.hhs.gov]

Pursuant to 42 CFR §424.535(c), CMS is establishing a re-enrollment bar for a period of [Insert amount of time] that shall begin 30 days after the postmark date of this letter. This re-enrollment bar only applies to your ability to submit a new enrollment application to the Medicare program. In order to re-enroll, you must meet all requirements for your provider or supplier type.

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

Sincerely,

[Name]
[Title]
[Company]

C. Revocation Letter Examples

Note that each example contains appeal rights for both CMS and the MAC, regardless of the example reason, so that the contractors may include the appropriate appeal address based on the provider or supplier type that has been revoked.

1. Abuse of Billing Revocation Letter Example

[month] [day], [year]

[Entity name]
[Address]
[City, State & ZIP Code]

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

Dear [Provider/Supplier Name]:

Your Medicare privileges are being revoked effective June 16, 2012 for the following reasons:

Revocation reason: 42 CFR §535(a)(8)

Specifically, you submitted 186 claims to Medicare for services provided after the date of death of 15 beneficiaries.

Right to Submit a Corrective Action Plan (CAP) and Reconsideration Request:

Corrective Action Plan: (Only if revoked under 42 C.F.R. § 424.535(a)(1))

You may submit a corrective action plan (CAP) in response to the revocation of Medicare billing privileges under 42 C.F.R. § 424.535(a)(1). You may also request a reconsideration (described below). If your Medicare billing privileges were revoked under authorities other than 42 C.F.R. § 424.535(a)(1), you may **only** submit a reconsideration request in response to those revocation bases.

The CAP is an opportunity to demonstrate that you have corrected the deficiencies identified above and thereby, establish your eligibility to maintain enrollment in the Medicare program. (Optional Coversheet sentence [To facilitate the processing of your CAP, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.]) The CAP must:

- Be received in writing within 35 calendar days of the date of this letter and mailed or emailed to the address below;
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
 - If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
 - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.
 - Authorized or delegated officials for groups cannot sign and submit a CAP on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that

individual from the group to act on his/her behalf.

- Provide evidence to demonstrate that you are in compliance with Medicare requirements.

(Insert correct address based on whether the MAC or CMS is responsible for reviewing the CAP)

| | | |
|------------------|---|--|
| [Name of MAC] | | Centers for Medicare & Medicaid |
| [Address] | o | Services |
| [City], ST [Zip] | r | Center for Program Integrity |
| | | Provider Enrollment & Oversight Group |
| | | Attn: Division of Compliance and Appeals |
| | | 7500 Security Boulevard |
| | | Mailstop AR-18-50 |
| | | Baltimore, MD 21244-1850 |

Or emailed to:

[Insert MAC email address]or
[ProviderEnrollmentAppeals@cms.hhs.gov]

Reconsideration Request:

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

Reconsideration requests must:

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
 - If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
 - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of

its representative with the submission of the reconsideration request.

- Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her behalf.

Providers and suppliers may:

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.
- Include an email address if you want to receive correspondence regarding your appeal via email.
- (If revoked under 42 C.F.R. § 424.535(a)(2)) Please note that you may not appeal through this process the merits of any exclusion by another Federal agency. Any further permissible administrative appeal involving the merits of such exclusion must be filed with the Federal agency that took the action.

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

The reconsideration request should be sent to:

(Insert correct address based on whether the MAC or CMS is responsible for handling the reconsideration.

[Name of MAC]

[Address]

[City], ST [Zip]

o

r

Centers for Medicare & Medicaid

Services

Center for Program Integrity

Provider Enrollment & Oversight Group

Attn: Division of Compliance and Appeals

7500 Security Boulevard

Mailstop AR-18-50

Baltimore, MD 21244-1850

Or emailed to:

[Insert MAC email address]or
[ProviderEnrollmentAppeals@cms.hhs.gov]

Pursuant to 42 CFR §424.535(c), CMS is establishing a re-enrollment bar for a period of [Insert amount of time] that shall begin 30 days after the postmark date of this letter. This re-enrollment bar only applies to your ability to submit a new enrollment application to the Medicare program. In order to re-enroll, you must meet all requirements for your provider or supplier type.

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

Sincerely,

[Name]
[Title]
[Company]

2. DMEPOS Supplier Revocation Letter Example

[month] [day], [year]

[Entity name]
[Address]
[City, State & ZIP Code]

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

Dear [Supplier Name]:

The purpose of this letter is to inform you that pursuant to 42 CFR 405.800, 42 CFR 57(e), and 42 CFR 424.535(a)(5), your Medicare supplier number [98765432101] for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) issued by the National Supplier Clearinghouse (NSC) is revoked. The effective date of this revocation has been made retroactive to April 26, 2012, which is the date the Centers for Medicare & Medicaid Services (CMS) determined that your practice location is not operational.

Pursuant to 42 CFR 424.535(c), NSC is establishing a re-enrollment bar for a period of two (2) year from the effective date of the revocation. This enrollment bar applies only to your participation in the Medicare program. In order to re-enroll, you must meet all requirements for your supplier type.

We have determined that you are not in compliance with the supplier standards noted below:

CFR 424.57(c) (7) Maintain a physical facility on an appropriate site, accessible to the public and staffed during posted hours of business with visible signage.

Recently a representative of the NSC attempted to conduct a visit of your facility on April 26, 2012. However, the visit was unsuccessful because your facility was closed, locked, and vacant. There was a "For Rent" sign on the window along with a sign directing customers to a nearby Rite Aid Pharmacy. Because we could not complete an inspection of your facility, we could not verify your compliance with the supplier standards. Based on a review of the facts, we have determined that your facility is not operational to furnish Medicare covered items and services. Thus, you are in violation of 42 CFR 424.535(a)(5).

CFR 424.57(c) (26) must meet the surety bond requirements specified in paragraph (d) of this section (CFR 424.57(d)).

We received a cancellation notice from Cook, Books & Hyde Surety indicating that the surety bond on file with the NSC number 99999999 has been cancelled effective January 19, 2012. You failed to maintain a valid surety bond as required by law.

Section 1834 (j) of the Social Security Act states that, with the exception of medical equipment and supplies furnished incident to a physician's service, no payment may be made by Medicare for items furnished by a supplier unless the supplier has a valid Medicare billing number. Therefore, any expenses for items you supply to a Medicare beneficiary on or after the effective date of the revocation of your billing numbers are your responsibility and not the beneficiary's, unless you have proof that you have notified the beneficiary in accordance with section 1834 (a) (18) (ii) of the Social Security Act and the beneficiary has agreed to take financial responsibility if the items you supply are not covered by Medicare. You will be required to refund on a timely basis to the beneficiary (and will be liable to the beneficiary for) any amounts collected from the beneficiary for such items. If you fail to refund the beneficiary as required under 1834 (j) (4) and 1879 (h) of the Social Security Act, you may be liable for Civil Monetary penalties.

If you believe that this determination is not correct, you may request a reconsideration before a contractor hearing officer. The reconsideration is an independent review and will be conducted by a person not involved in the initial determination. You must request the reconsideration in writing to this office within 60 calendar days of the postmark date of this letter. The reconsideration must state the issues or findings of fact with which you disagree and the reasons for

disagreement. You may submit additional information with the reconsideration that you believe may have a bearing on the decision. The reconsideration must be signed and dated by the authorized or delegated official within the entity. Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review.

In addition, if submitting a CMS 855S application after the re-enrollment bar has expired, 42 CFR 424.57(d)(3)(ii) states suppliers will be required to maintain an elevated surety bond amount of \$50,000 for each final adverse action imposed. Therefore, if you do not request a reconsideration of this decision or receive an unfavorable decision through the administrative review process, you must submit an elevated surety bond. Please note this amount is in addition to, and not in lieu of, the base \$50,000 amount that must be maintained.

The reconsideration request should be sent to:

[National Supplier Clearinghouse Contractor name]
[Address]
[City], ST [Zip]

If you choose not to request a reconsideration of this decision, or you do not receive a favorable decision through the administrative review process, you must wait two (2) year(s) before resubmitting your CMS-855S application, per the re-enrollment bar cited above. Applications received in the NSC prior to this timeframe will be returned.

If you have any questions, please contact our office at (866) 238-9652 between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name]
[Title]
[Company]

3. MDPP Supplier Use of an Ineligible Coach Revocation Letter Example

[month] [day], [year]

[Entity name]
[Address]
[City, State & ZIP Code]

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

Dear [MDPP Supplier Name]:

Your Medicare privileges are being revoked effective June 16, 2018 for the following reasons:

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

Per 42 CFR §424.205(d)(3), MDPP suppliers must only use eligible coaches.

Revocation reason: 42 CFR §424.205(h)(v) – Use of an Ineligible coach

Specifically, you were notified on April 1, 2018 that John Doe was ineligible to serve as an MDPP coach due to an assault conviction in June 2015. On April 15, 2018, you submitted a corrective action plan (CAP), which removed John Doe from Section 7 of your Form CMS-20134. On June 1, 2018, you submitted a claim with the NPI of John Doe for services rendered May 1st, after he was removed from your coach roster. This indicates knowingly use of an ineligible MDPP coach.

Revocations under 42 CFR §424.205(h)(v) are not eligible for CAP submission. The revocation becomes effective 30 days after the date of this notice.

Right to Submit a Corrective Action Plan (CAP) and Reconsideration Request:

Corrective Action Plan: (Only if revoked under 42 C.F.R. § 424.535(a)(1))

You may submit a corrective action plan (CAP) in response to the revocation of Medicare billing privileges under 42 C.F.R. § 424.535(a)(1). You may also request a reconsideration (described below). If your Medicare billing privileges were revoked under authorities other than 42 C.F.R. § 424.535(a)(1), you may **only** submit a reconsideration request in response to those revocation bases.

The CAP is an opportunity to demonstrate that you have corrected the deficiencies identified above and thereby, establish your eligibility to maintain enrollment in the Medicare program. (Optional Coversheet sentence [To facilitate the processing of your CAP, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.]) The CAP must:

- Be received in writing within 35 calendar days of the date of

this letter and mailed or emailed to the address below;

- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
 - If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
 - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.
 - Authorized or delegated officials for groups cannot sign and submit a CAP on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her behalf.
- Provide evidence to demonstrate that you are in compliance with Medicare requirements.

(Insert correct address based on whether the MAC or CMS is responsible for reviewing the CAP)

| | | |
|------------------|---|--|
| [Name of MAC] | | Centers for Medicare & Medicaid |
| [Address] | o | Services |
| [City], ST [Zip] | r | Center for Program Integrity |
| | | Provider Enrollment & Oversight Group |
| | | Attn: Division of Compliance and Appeals |
| | | 7500 Security Boulevard |
| | | Mailstop AR-18-50 |
| | | Baltimore, MD 21244-1850 |

Or emailed to:

[Insert MAC email address]or
[ProviderEnrollmentAppeals@cms.hhs.gov]

Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. (Optional Coversheet sentence [To facilitate the

processing of your reconsideration request, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.))

Reconsideration requests must:

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

Providers and suppliers may:

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.
- Include an email address if you want to receive correspondence regarding your appeal via email.
- (If revoked under 42 C.F.R. § 424.535(a)(2)) Please note that you may not appeal through this process the merits of any exclusion by another Federal agency. Any further permissible administrative appeal involving the merits of such exclusion

must be filed with the Federal agency that took the action.

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

The reconsideration request should be sent to:

(Insert correct address based on whether the MAC or CMS is responsible for handling the reconsideration.

| | | |
|------------------|---|--|
| [Name of MAC] | | Centers for Medicare & Medicaid |
| [Address] | o | Services |
| [City], ST [Zip] | r | Center for Program Integrity |
| | | Provider Enrollment & Oversight Group |
| | | Attn: Division of Compliance and Appeals |
| | | 7500 Security Boulevard |
| | | Mailstop AR-18-50 |
| | | Baltimore, MD 21244-1850 |

Or emailed to:

[Insert MAC email address]or
[ProviderEnrollmentAppeals@cms.hhs.gov]

Pursuant to 42 CFR §424.535(c), CMS is establishing a re-enrollment bar for a period of [Insert amount of time] that shall begin 30 days after the postmark date of this letter. This re-enrollment bar only applies to your ability to submit a new enrollment application to the Medicare program. In order to re-enroll, you must meet all requirements for your provider or supplier type.

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

Sincerely,

[Name]
[Title]
[Company]

10.7.10 – Corrective Action Plan (CAP) Model Letters (Rev. 10611; Issued: 03-19-21; Effective:11-19-20; Implementation: 11-19-20)

A. CAP Withdrawn Acknowledgement Template

(To be sent by hard-copy mail and email if email address is provided.
Optional to send via fax if a valid fax number is available).

1. Email Template

To: [Email address provided by the person who submitted the CAP]

Subject: Medicare Provider Enrollment CAP re: [Provider/Supplier
Name]

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

We are in receipt of your written withdrawal request in regard to your corrective action plan (CAP) received on [Month] [DD], [YYYY]. [MAC Name] has not yet issued a decision regarding your CAP. Therefore, [MAC Name] considers your CAP dated [Month] [DD], [YYYY] to be withdrawn. As a result, a decision will not be issued in response to your CAP.

If you have not yet filed a reconsideration request, please be advised that failure to timely submit a reconsideration request is deemed a waiver of all further administrative review.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address] [Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

2. Hard-Copy Letter Template

[Month] [DD], [YYYY]

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

Re: Corrective Action Plan Decision
Legal Business Name: [Provider/Supplier Name] (as it appears in
PECOS)
NPI: [XXXXXXXXXXXX]
PTAN: [XXXXXX]
Reference Number: [XXXX] (optional)

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

We are in receipt of your written withdrawal request in regard to your
corrective action plan (CAP) received on [Month] [DD], [YYYY].
[MAC Name] has not yet issued a decision regarding your CAP.
Therefore, [MAC Name] considers your CAP dated [Month] [DD],
[YYYY] to be withdrawn. As a result, a decision will not be issued in
response to your CAP.

If you have not yet filed a reconsideration request, please be advised
that failure to timely submit a reconsideration request is deemed a
waiver of all further administrative review.

If you have any further questions, please forward your inquiries to
[MAC Appeal Receipt Email Address] or mail it to the following
address:

[MAC Appeal Receipt Address] [Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

**B. CAP Receipt Acknowledgement Email Template to
Provider/Supplier/ Representative**

(To be sent by hard-copy mail and email if email address is provided.
Optional to send via fax if a valid fax number is available).

1. Email Template

To: [Email address provided by the person who submitted the CAP]

Subject: Medicare Provider Enrollment CAP re: [Provider/Supplier
Name]

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

We are in receipt of your corrective action plan (CAP) on behalf of [Provider/Supplier Name]. Please be advised that [MAC Name] has 60 calendar days to review your CAP and render a decision.

If you have additional information that you would like a hearing officer to consider during the CAP review you must submit that information prior to a decision being issued.

Please be advised that failure to timely submit a reconsideration request is deemed a waiver of all further administrative review.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address] [Call Center Telephone Number]

Sincerely

,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

2. Hard-Copy Letter Template

[Month] [DD], [YYYY]

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

Re: Corrective Action Plan Decision
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXXX]
Reference Number: [XXXX] (optional)

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

We are in receipt of your corrective action plan (CAP) on behalf of [Provider/Supplier Name]. Please be advised that [MAC Name] has 60 calendar days to review your CAP and render a decision.

If you have additional information that you would like a hearing officer to consider during the CAP review you must submit that information prior to a decision being issued.

Please be advised that failure to timely submit a reconsideration request is deemed a waiver of all further administrative review.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address] [Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

**C. CAP Decision Email Template to
Provider/Supplier/Representative**

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

To: [Email address provided by the person who submitted the CAP]

Subject: Medicare Provider Enrollment CAP re: [Provider/Supplier Name]

(Be sure to attach a copy of the final decision[s] in PDF format.)

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

Please see the attached decision regarding your Medicare Provider Enrollment CAP.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address] [Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]

[Position of Hearing Officer]

[MAC Name]

D. CAP Not Actionable (Moot) Model Letter

(To be sent by hard-copy mail and email if email address is provided.
Optional to send via fax if a valid fax number is available).

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of CAP]

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

[City], [State] [Zip Code]

Re: Corrective Action Plan Decision

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

NPI: [XXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXX] (optional)

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

This letter is in response to the CAP received by [MAC Name] based on the initial determination letter, dated [Month] [DD], [YYYY].

In correspondence dated [Month] [DD], [YYYY], the initial determination letter, dated [Month] [DD], [YYYY] informing you of the [denial of your Medicare enrollment application or revocation of your Medicare billing privileges] was [insert description] (describe action taken in regards to the initial determination, i.e. rescission of denial or revocation). For your convenience, a copy of the initial determination is included. Therefore, the issue set forth in the CAP is no longer actionable. This issue is moot, and we are unable to render a decision on the matter.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address] [Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]

[Position of Hearing Officer]

[MAC Name]

E. Untimely CAP Dismissal Model Letter

(To be sent by hard-copy mail and email if email address is provided.
Optional to send via fax if a valid fax number is available).

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of CAP]

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

[City], [State] [Zip Code]

Re: Corrective Action Plan Decision

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

NPI: [XXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXXX] (optional)

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

This letter is in response to the CAP received by [MAC Name] based on the initial determination letter, dated [Month] [DD], [YYYY].

[MAC Name] is unable to accept your CAP as it was not timely submitted. The initial determination letter was dated [Month] [DD], [YYYY]. A CAP must be received within 35 calendar days of the date of the initial determination letter. Your CAP was not received until [Month] [DD], [YYYY], which is beyond the applicable submission time frame. [Provider/Supplier/Representative] failed to show good cause for its late request. Therefore, [MAC Name] is unable to render a decision in this matter.

Please refer to the initial determination letter, dated [Month] [DD], [YYYY], for instructions on how to properly file a reconsideration request. If you have already submitted a reconsideration request, you will receive further communication related to that submission. Failure to timely file a reconsideration request is deemed a waiver of all further administrative review.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address] [Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]

[Position of Hearing Officer]

[MAC Name]

F. Improperly Signed CAP Dismissal Model Letter

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of CAP]

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

[City], [State] [Zip Code]

Re: Corrective Action Plan Decision

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

NPI: [XXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXX] (optional)

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

This letter is in response to the corrective action plan (CAP) received by [MAC Name] based on the initial determination letter, dated [Month] [DD], [YYYY].

[MAC Name] is unable to accept your CAP as it was not signed by an authorized or delegated official currently on file in your Medicare enrollment record, the individual provider or supplier, or a properly appointed representative. The signature requirement was stated in the initial determination letter, dated [Month] [DD], [YYYY], as well as in Chapter 10 of the Medicare Program Integrity Manual.

Please refer to the initial determination letter, dated [Month] [DD], [YYYY], for instructions on how to properly file a reconsideration request.

If you have already submitted a reconsideration request, you will receive further communication related to that submission. Failure to timely file a reconsideration request is deemed a waiver of all further administrative review.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address] [Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

G. No CAP Rights Dismissal Model Letter

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [DD], [YYYY]

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

Re: Corrective Action Plan Decision
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXXX]
Reference Number: [XXXX] (optional)

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

This letter is in response to the corrective action plan (CAP) received by [MAC Name] based on the initial determination letter, dated [Month] [DD], [YYYY].

[MAC Name] is unable to accept your CAP. A provider or supplier may only submit a CAP if there has been a denial of enrollment in the Medicare program under 42 C.F.R § 424.530(a)(1) or the revocation of Medicare

billing privileges under 42 C.F.R. § 424.535(a)(1). Your enrollment was not denied or revoked under one of the aforementioned authorities. Therefore, a CAP decision cannot be rendered based on this submission.

Please refer to the initial determination letter, dated [Month] [DD], [YYYY], for instructions on how to properly file a reconsideration request. If you have already submitted a reconsideration request, you will receive further communication related to that submission. Please be advised that failure to timely submit a reconsideration request is deemed a waiver of all further administrative review.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address] [Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

H. Not Eligible to Submit CAP Dismissal Model Letter

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [DD], [YYYY]

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

Re: Corrective Action Plan Decision
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

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

This letter is in response to the [corrective action plan (CAP)] received by [MAC Name], based on the [Month] [DD], [YYYY] initial determination.

[MAC Name] is unable to accept your [CAP] submission because the action taken in regards to your Medicare enrollment is not an initial determination subject to administrative review. More specifically, an initial determination has not been made as described in 42 C.F.R. § 498.3(b). Under 42 C.F.R. § 498.5(l), appeal rights extend only to initial determinations related to the denial or revocation of Medicare billing privileges.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address] [Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

I. CAP Signature Development Model Letter

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [DD], [YYYY]

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

Re: Corrective Action Plan Decision
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

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

We are in receipt of your CAP submission, received on [Month] [DD], [YYYY].

(If the submission is not properly signed, use the following.) [Your submission is not appropriately signed, as stated in the initial determination letter and in the Medicare Program Integrity Manual, Ch. 10, Section 10.6.18. [MAC Name] is requesting that you submit a CAP that is properly signed by the individual provider, supplier, the authorized or delegated official, or a properly appointed representative. Your properly signed submission must be received within 15 calendar days of the date of this notice. If you do not timely respond to this request, your CAP submission may be dismissed.]

(If the submission is missing a statement by the attorney, use the following.) [Your submission is missing an attorney statement that he or she has the authority to represent the provider or supplier. [MAC Name] is requesting that you submit a CAP that includes an attorney statement that he or she has the authority to represent the provider or supplier within 15 calendar days of the date of this notice. If you do not timely respond to this request, your CAP submission may be dismissed.]

(If the submission is missing a signed written notice from the provider/supplier authorizing the representative to act on his/her/its behalf, use the following.) [Your submission is missing a written notice of the appointment of a representative signed by the provider or supplier. [MAC Name] is requesting that you submit written notice of the appointment of a representative that is signed by the provider or supplier within 15 calendar days of the date of this notice. If you do not timely respond to this request, your CAP submission may be dismissed.]

Your submission should be sent to [MAC Appeal Receipt Email Address] or mailed to the following address:

[MAC Appeal Receipt Address] [MAC Fax number]

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

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]

[Position of Hearing Officer]

[MAC Name]

J. Favorable CAP Model Letter in Response to an Enrollment Denial

(To be sent by hard-copy mail and email if email address is provided.
Optional to send via fax if a valid fax number is available).

[Month] [DD], [YYYY]

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

Re: Corrective Action Plan Decision
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXXX]
Reference Number: [XXXX] (optional)

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

This letter is in response to the corrective action plan (CAP) received by [MAC Name] based on an enrollment denial. The initial determination letter was dated [Month] [DD], [YYYY] and the CAP was received on [Month] [DD], [YYYY]; therefore, this CAP is considered timely. (if the CAP is untimely, but good cause has been found to accept the CAP, use the following [This CAP was not timely submitted, but a good cause waiver has been granted.]) The following decision is based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

DENIAL REASON:

- 42 C.F.R. § 424.530(a)(1)

OTHER APPLICABLE AUTHORITIES:

- (Ex: Medicare Program Integrity Manual chapter 10, section 10.XX)

EXHIBITS:

- Exhibit 1: (Ex.: CAP, signed by Jane Doe, dated [Month] [DD], [YYYY].)
- Exhibit 2: (Ex: Copy of a medical license for Jane Doe from the Wisconsin Medical Board, effective [Month] [DD], [YYYY].)

(In this section list each document submitted by the provider or supplier. Each exhibit should include the date, as well as a brief description of the

document. You shall also include all other documentation not submitted by the provider that the hearing officer reviewed in making the decision, e.g., enrollment applications, development letters, etc.)

BACKGROUND:

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

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

CORRECTIVE ACTION PLAN ANALYSIS:

[A [Provider/Supplier Name] may only submit a corrective action plan for noncompliance under 42 C.F.R. § 424.530(a)(1). If the initial determination was based on any other denial reasons other than 42 C.F.R. § 424.530(a)(1), this decision will not review those authorities.]

(A CAP is an opportunity to correct the deficiencies identified in the initial determination. This section should include: A clear explanation of why the denial was overturned in sufficient detail for the provider or supplier to understand the decision and; if applicable: the nature of the provider or supplier's deficiencies, the regulatory or other policy basis to support each reason for the denial, and an explanation of how the provider or supplier now meets the enrollment criteria or requirements. This section shall not reference a CAP decision without explaining how and why you came to that decision.)

DECISION:

(A short conclusory restatement. Approval date should be based on the date the provider or supplier came into compliance with all applicable Medicare requirements.)

(Ex: On [Month] [DD], [YYYY], Jane Doe's medical license expired. However, on [Month] [DD], [YYYY] John Smith submitted a copy of his renewed medical license, which was reinstated back to the date of expiration by the Wisconsin Medical Board. As a result, [MAC Name] finds that Jane Doe came into compliance with the applicable Medicare requirements on [Month] [DD], [YYYY]. Therefore, [MAC Name] overturns the denial of Jane Doe's Medicare enrollment application as it relates to 42 C.F.R. § 424.530(a)(1).

This decision is a **FAVORABLE DECISION**. To effectuate this decision, [MAC name] will continue processing the enrollment application.

(If additional information is needed from the provider or supplier in order to reactivate the enrollment, the MAC shall state what information is needed from the provider or supplier in this CAP decision. MACs shall state that the requested information/documentation must be received within 30 calendar days of the date of this decision letter.)

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address] [Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]

[Position of Hearing Officer]

[MAC Name]

K. Favorable CAP Model Letter for Revocation Determination

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of CAP]

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

[City], [State] [Zip Code]

Re: Corrective Action Plan Decision

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

NPI: [XXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXX] (optional)

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

This letter is in response to the corrective action plan (CAP) received by [MAC Name] based on a revocation of Medicare billing privileges. The initial determination letter was dated [Month] [DD], [YYYY] and the CAP was received by [MAC Name] on [Month] [DD], [YYYY]; therefore, this appeal is considered timely. (if the CAP is untimely, but good cause has

been found to accept the CAP, use the following [This CAP was not timely submitted, but a good cause waiver has been granted.]) The following decision is based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, evidence in the file, and any information received before this decision was rendered.

REVOCATION REASON:

- 42 C.F.R. § 424.535(a)(1)

OTHER APPLICABLE AUTHORITIES:

- (Ex: Medicare Program Integrity Manual chapter 10, section 10.XX)

EXHIBITS:

- Exhibit 1: (Ex.: CAP, signed by Jane Doe, dated [Month] [DD], [YYYY].)
- Exhibit 2: (Ex: Copy of a medical license for Jane Doe from the Wisconsin Medical Board, effective [Month] [DD], [YYYY].)

(In this section list each document submitted by the provider or supplier. Each exhibit should include the date, as well as a brief description of the document. You shall also include all other documentation not submitted by the provider that the hearing officer reviewed in making the decision, e.g., enrollment applications, development letters, etc.)

BACKGROUND:

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

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

CORRECTIVE ACTION PLAN ANALYSIS:

[A [Provider/Supplier Name] may only submit a corrective action plan for noncompliance. If the initial determination was based on revocation reasons other than 42 C.F.R. § 424.535(a)(1), this decision will not review those authorities.]

(A CAP is an opportunity to correct the deficiencies identified in the initial determination. This section should include: A clear explanation of why the revocation is being upheld or overturned in sufficient detail for the

provider or supplier to understand the decision and; if applicable: the nature of the provider or supplier's deficiencies, the regulatory basis to support the revocation for noncompliance, and an explanation of how the provider or supplier now meets the enrollment compliance criteria or requirements. This section shall not reference a CAP decision without explaining how and why you came to that decision.)

DECISION:

(A short conclusory restatement.)

(Ex: On [Month] [DD], [YYYY], Jane Doe's medical license was suspended. However, as part of her CAP, Jane Doe submitted a revised order from the Wisconsin Medical Board, which reinstated her medical back license back to the date of suspension. As a result, [MAC Name] finds that Jane Doe came into compliance with the applicable Medicare requirements on [Month] [DD], [YYYY]. Therefore, [MAC Name] overturns the revocation of Jane Doe's Medicare billing privileges as it relates to 42 C.F.R. § 424.535(a)(1).

This decision is a **FAVORABLE DECISION**. To effectuate this decision, [MAC name] [will reinstate/has reinstated] your Medicare billing privileges, effective [Month] [DD], [YYYY].

(The reinstatement date is based on chapter 10 of the MPIM and the date of the provider's or supplier's revocation or the date the provider's or supplier's license was reinstated if the revocation involves a licensure issue.)

(If additional information is needed from the provider or supplier in order to reactivate the enrollment, the MAC shall state what information is needed from the provider or supplier in this CAP decision. MACs shall state that the requested information/documentation must be received within 30 calendar days of the date of this decision letter.)

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address] [Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

L. Unfavorable CAP Model Letter in Response to an Enrollment Denial

(To be sent by hard-copy mail and email if email address is provided.
Optional to send via fax if a valid fax number is available).

[Month] [DD], [YYYY]

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

Re: Corrective Action Plan Decision
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

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

This letter is in response to the corrective action plan (CAP) received by [MAC Name] based on an enrollment denial. The initial determination letter was dated [Month] [DD], [YYYY] and the CAP was received by [MAC Name] on [Month] [DD], [YYYY]; therefore, this appeal is considered timely. (if the CAP is untimely, but good cause has been found to accept the CAP, use the following [This CAP was not timely submitted, but a good cause waiver has been granted.]) The following decision is based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

DENIAL REASON:

- 42 C.F.R. § 424.530(a)(1)

OTHER APPLICABLE AUTHORITIES:

- (Ex: Medicare Program Integrity Manual chapter 10, section 10.XX)

EXHIBITS:

- Exhibit 1: (Ex.: (Ex.: CAP, signed by Jane Doe, dated [Month] [DD], [YYYY].)
- Exhibit 2: (Ex: Copy of a medical license for Jane Doe from the Wisconsin Medical Board, effective [Month] [DD], [YYYY].)

(In this section list each document submitted by the provider or supplier. Each exhibit should include the date, as well as a brief description of the document. You shall also include all other documentation not submitted by the provider that the hearing officer reviewed in making the decision, e.g., enrollment applications, development letters, etc.)

BACKGROUND:

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

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

CORRECTIVE ACTION PLAN ANALYSIS:

[A [Provider/Supplier Name] may only submit a corrective action plan for noncompliance under 42 C.F.R. § 424.530(a)(1). If the initial determination was based on any other denial reasons other than 42 C.F.R. § 424.530(a)(1), this decision will not review those authorities.]

(A CAP is an opportunity to correct the deficiencies identified in the initial determination. This section should include: A clear explanation of why the denial is being upheld in sufficient detail for the provider or supplier to understand the decision and; if applicable: the nature of the provider or supplier's deficiencies, the regulatory or other policy basis to support each reason for the denial, and an explanation of how the provider or supplier now meets the enrollment criteria or requirements. This section shall not reference a CAP decision without explaining how and why you came to that decision.)

DECISION:

(A short conclusory restatement.)

(On [Month] [DD], [YYYY], Jane Doe's medical license was suspended by the Wisconsin Medical Board. [MAC Name] has confirmed that Jane Doe's medical license remains suspended. As a result, [MAC Name] upholds the denial of Jane Doe's Medicare enrollment application under 42 C.F.R. § 424.530(a)(1).)

This decision is an **UNFAVORABLE DECISION**. [MAC name] concludes that the CAP does not correct the deficiencies that led to the denial of your Medicare enrollment. As a result, the denial of your Medicare enrollment is upheld.

Failure to timely file a reconsideration request is deemed a waiver of all further administrative review. However, if you have submitted a reconsideration request, a separate decision is forthcoming.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address] [Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

M. Unfavorable CAP Model Letter for Revocation Determination

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [DD], [YYYY]

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

Re: Corrective Action Plan Decision
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

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

This letter is in response to the corrective action plan (CAP) received by [MAC Name] based on a revocation of Medicare billing privileges. The initial determination letter was dated [Month] [DD], [YYYY] and the CAP

was received by [MAC Name] on [Month] [DD], [YYYY]; therefore, this appeal is considered timely. (if the CAP is untimely, but good cause has been found to accept the CAP, use the following [This CAP was not timely submitted, but a good cause waiver has been granted.]) The following decision is based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

REVOCATION REASON:

- 42 C.F.R. § 424.535(a)(1)

OTHER APPLICABLE AUTHORITIES:

- (Ex: Medicare Program Integrity Manual chapter 10, section 10.XX)

EXHIBITS:

- Exhibit 1: (Ex.: (Ex.: CAP, signed by Jane Doe, dated [Month] [DD], [YYYY].)
- Exhibit 2: (Ex: Copy of a medical license for Jane Doe from the Wisconsin Medical Board, effective [Month] [DD], [YYYY].)

(In this section list each document submitted by the provider or supplier. Each exhibit should include the date, as well as a brief description of the document. You shall also include all other documentation not submitted by the provider that the hearing officer reviewed in making the decision, e.g., enrollment applications, development letters, etc.)

BACKGROUND:

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

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

CORRECTIVE ACTION PLAN ANALYSIS:

[A [Provider/Supplier Name] may only submit a corrective action plan for noncompliance. If the initial determination was based on revocation reasons other than 42 C.F.R. § 424.535(a)(1), this decision will not review those authorities.]

(A CAP is an opportunity to correct the deficiencies identified in the initial determination. This section should include: A clear explanation of why the

revocation is being upheld in sufficient detail for the provider or supplier to understand the decision and; if applicable: the nature of the provider or supplier's deficiencies, the regulatory or other policy basis to support compliance and how the provider or supplier now meets the enrollment criteria or requirements. This section shall not reference a CAP decision without explaining how and why you came to that decision.)

DECISION:

(A short conclusory restatement.)

(On [Month] [DD], [YYYY], Jane Doe's medical license was suspended by the Wisconsin Medical Board. Jane Doe has not submitted evidence to demonstrate that her medical license has been reinstated. In addition, [MAC Name] has confirmed that Jane Doe's medical license remains suspended. As a result, [MAC Name] upholds the revocation of Jane Doe's Medicare billing privileges under 42 C.F.R. § 424.535(a)(1).)

This decision is an **UNFAVORABLE DECISION**. [MAC name] concludes that the CAP did not correct the deficiencies noted in the implementation of the revocation. As a result, the revocation of your Medicare billing privileges is upheld.

Failure to timely file a reconsideration request is deemed a waiver of all further administrative review. However, if you have submitted a reconsideration request, a separate decision is forthcoming.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address] [Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

N. CAP Further Information Required for Development Model Letter

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

To: [Email address provided by the person who submitted the CAP.]

Subject: Medicare Provider Enrollment CAP re: [Provider/Supplier Name]

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

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

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

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

[City], [State] [Zip Code]

Re: CAP Decision

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)

NPI: [XXXXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXX] (Internal Tracking)

Dear [Name of the person(s) who submitted the CAP]:

On [Month] [DD], [YYYY], [MAC Name] issued a CAP decision. As stated in the [Month] [DD], [YYYY] CAP decision letter, the approval of [Provider/Supplier Name]'s Medicare enrollment is contingent upon the submission of [list required documentation]. Please send the required documentation within 30 calendar days to:

[MAC CAP Receipt Address]

[MAC CAP Receipt Email Address] [MAC CAP Receipt Fax Number]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]

[Position of Hearing Officer]

[MAC Name]

10.7.11 – Reconsideration Request Model Letters
(Rev. 10611; Issued: 03-19-21; Effective:11-19-20; Implementation:
11-19-20)

A. Reconsideration Request Withdrawn Acknowledgement Template

(To be sent by hard-copy mail and email if email address is provided.
Optional to send via fax if a valid fax number is available).

1. Email Template

To: [Email address provided by the person who submitted the
reconsideration request]

Subject: Medicare Provider Enrollment Reconsideration Request re:
[Provider/Supplier Name]

Dear [Name of the person(s) who submitted the reconsideration
request]:

We are in receipt of your written withdrawal request in regard to your
reconsideration request received on [Month] [DD], [YYYY]. [MAC
Name] has not yet issued a reconsidered decision, and therefore, [MAC
Name] considers your reconsideration request to be withdrawn. As a
result, a decision will not be issued in response to your reconsideration
request.

Please be advised that failure to timely submit a reconsideration request
is deemed a waiver of all further administrative review.

If you have any further questions, please forward your inquiries to
[MAC Appeal Receipt Email Address] or mail it to the following
address:

[MAC Appeal Receipt Address] [Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

2. Hard-Copy Letter Template

[Month] [Day], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of Reconsideration Request]

[Address] (Address from which the Reconsideration Request was sent)

[City], [State] [Zip Code]

Re: Reconsideration Request Decision

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)

NPI: [XXXXXXXXXXXX]

PTAN: [XXXXX]

Reference Number: [XXXX] (optional)

Dear [Name of the person(s) who submitted the reconsideration request]:

We are in receipt of your written withdrawal request in regard to your reconsideration request received on [Month] [DD], [YYYY]. [MAC Name] has not yet issued a reconsidered decision, and therefore, [MAC Name] considers your reconsideration request to be withdrawn. As a result, a decision will not be issued in response to your reconsideration request.

Please be advised that failure to timely submit a reconsideration request is deemed a waiver of all further administrative review.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address]

[Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]

[Position of Hearing Officer]

[MAC Name]

B. Reconsideration Request Receipt Acknowledgement Template to Provider/Supplier/Representative

(To be sent by hard-copy mail and email if email address is provided.
Optional to send via fax if a valid fax number is available).

1. Email Template

To: [Email address provided by the person who submitted the
reconsideration request]

Subject: Medicare Provider Enrollment Reconsideration Request re:
[Provider/Supplier Name]

Dear [Name of the person(s) who submitted the reconsideration
request]:

We are in receipt of your reconsideration request on behalf of
[Provider/Supplier Name]. Please be advised that [MAC Name] has 90
calendar days to review your reconsideration request and render a
decision.

If you have additional information that you would like a hearing
officer to consider during the reconsideration or, if necessary, an
administrative law judge (ALJ) to consider during a hearing, you must
submit that information to the hearing office before a decision is
rendered. This is your only opportunity to submit information during
the administrative appeals process; you will not have another
opportunity to do so unless an ALJ specifically allows you to do so
under 42 C.F.R. §498.56(e).

If you have any further questions, please forward your inquiries to
[MAC Appeal Receipt Email Address] or mail it to the following
address:

[MAC Appeal Receipt Address] [Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

2. Hard-Copy Letter Template

[Month] [Day], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of Reconsideration Request]
[Address] (Address from which the Reconsideration Request was sent)
[City], [State] [Zip Code]

Re: Reconsideration Request Decision
Legal Business Name: [Provider/Supplier Name] (as it appears in
PECOS)
NPI: [XXXXXXXXXXXX]
PTAN: [XXXXXX]
Reference Number: [XXXX] (optional)

Dear [Name of the person(s) who submitted the reconsideration
request]:

We are in receipt of your reconsideration request on behalf of
[Provider/Supplier Name]. Please be advised that [MAC Name] has 90
calendar days to review your reconsideration request and render a
decision.

If you have additional information that you would like a hearing
officer to consider during the reconsideration or, if necessary, an
administrative law judge (ALJ) to consider during a hearing, you must
submit that information to the hearing office before a decision is
rendered. This is your only opportunity to submit information during
the administrative appeals process; you will not have another
opportunity to do so unless an ALJ specifically allows you to do so
under 42 C.F.R. §498.56(e).

If you have any further questions, please forward your inquiries to
[MAC Appeal Receipt Email Address] or mail it to the following
address:

[MAC Appeal Receipt Address] [Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

**C. Reconsideration Request Decision Email Template to
Provider/Supplier/Representative**

(To be sent by hard-copy mail and email if email address is provided.
Optional to send via fax if a valid fax number is available).

To: [Email address provided by the person who submitted the Reconsideration Request]

Subject: Medicare Provider Enrollment Reconsideration Request re:
[Provider/Supplier Name]

Dear [Name of the person(s) who submitted the reconsideration]

(Be sure to attach a copy of the final decision[s] in PDF format.)

Dear [Name of the person(s) who submitted the Reconsideration Request]:

Please see the attached decision regarding your Medicare Provider Enrollment Reconsideration Request.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address] [Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]

[Position of Hearing Officer]

[MAC Name]

D. Reconsideration Request Not Actionable (Moot) Model Letter

(To be sent by hard-copy mail and email if email address is provided.
Optional to send via fax if a valid fax number is available).

[Month] [Day], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of Reconsideration Request]

[Address] (Address from which the Reconsideration Request was sent)

[City], [State] [Zip Code]

Re: Reconsideration Request Decision

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)

NPI: [XXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXX] (optional)

Dear [Name of the person(s) who submitted the reconsideration request]:

This letter is in response to the reconsideration request received by [MAC Name] based on the initial determination letter, dated [Month] [DD], [YYYY].

In correspondence dated [Month] [DD], [YYYY], the initial determination letter, dated [Month] [DD], [YYYY] informing you of the [denial of your Medicare enrollment application or revocation of your Medicare billing privileges] was [insert description] (describe action taken in regards to the initial determination, i.e. rescission of the denial or revocation). For your convenience, a copy of the initial determination is included. Therefore, the issue set forth in the reconsideration request is no longer actionable. This issue is moot, and we are unable to render a decision on the matter.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address] [Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

E. Untimely Reconsideration Request Dismissal Model Letter

(To be sent by hard-copy mail and email if email address is provided.
Optional to send via fax if a valid fax number is available).

[Month] [Day], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Reconsideration Request]
[Address] (Address from which the Reconsideration Request was sent)
[City], [State] [Zip Code]

Re: Reconsideration Request Decision
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

Dear [Name of the person(s) who submitted the reconsideration request]:

This letter is in response to the reconsideration request received by [MAC Name], based on the initial determination letter dated [Month] [DD], [YYYY].

[MAC Name] is unable to accept your reconsideration request as it was not timely submitted. The initial determination letter was dated [Month] [DD], [YYYY]. A reconsideration request must be received within 65 calendar days of the date of the initial determination letter. Your reconsideration request was not received by [MAC Name] until [Month] [DD], [YYYY], which is beyond the applicable submission time frame. You have failed to show good cause for your late request. Therefore, [MAC Name] is unable to render a decision in this matter.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address] [Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

F. Improperly Signed Reconsideration Request Dismissal Model Letter

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [Day], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Reconsideration Request]
[Address] (Address from which the Reconsideration Request was sent)
[City], [State] [Zip Code]

Re: Reconsideration Request Decision
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

Dear [Name of the person(s) who submitted the reconsideration request]:

This letter is in response to the reconsideration request received by [MAC Name], based on the [Month] [DD], [YYYY] initial determination letter.

[MAC Name] is unable to accept your reconsideration request as it was not signed by an authorized or delegated official currently on file in your Medicare enrollment record, the individual provider or supplier, or a properly appointed representative. The signature requirement is stated in the [Month] [DD], [YYYY] initial determination letter, as well as in Chapter 10 of the Medicare Program Integrity Manual.

Please be advised that failure to timely submit a proper reconsideration request is deemed a waiver of all further administrative review.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address] [Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

G. Not Eligible to Submit Reconsideration Request Dismissal Model Letter

(To be sent by hard-copy mail and email if email address is provided.
Optional to send via fax if a valid fax number is available).

[Month] [Day], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Reconsideration Request]
[Address] (Address from which the Reconsideration Request was sent)
[City], [State] [Zip Code]

Re: Reconsideration Request Decision
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXXX] (optional)

Dear [Name of the person(s) who submitted the Reconsideration Request]:

This letter is in response to the [reconsideration request] received by [MAC Name], based on the [Month] [DD], [YYYY] initial determination.

[MAC Name] is unable to accept your [reconsideration request] submission because the action taken in regards to your Medicare enrollment is not an initial determination subject to administrative review. More specifically, an initial determination has not been made as described in 42 C.F.R. § 498.3(b). Under 42 C.F.R. § 498.5(l), appeal rights related to provider enrollment extend only from initial determinations.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address] [Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

H. Reconsideration Request Signature Development Model Letter

(To be sent by hard-copy mail and email if email address is provided.
Optional to send via fax if a valid fax number is available).

[Month] [Day], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Reconsideration Request]
[Address] (Address from which the Reconsideration Request was sent)
[City], [State] [Zip Code]

Re: Reconsideration Request Decision
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXXX]
Reference Number: [XXXX] (optional)

Dear [Name of the person(s) who submitted the Reconsideration Request]:

We are in receipt of your reconsideration submission, received on [Month] [DD], [YYYY]. (If the submission is not properly signed, use the following.) [Your submission is not appropriately signed, as required in the Medicare Program Integrity Manual, Ch. 10, Section 10.6.18. [MAC Name] is requesting that you submit a reconsideration request that is properly signed by the individual provider, supplier, the authorized or delegated official, or a representative. Your properly signed submission must be received within 15 calendar days of the date of this notice. If you do not timely respond to this request, your reconsideration submission may be dismissed.]

(If the submission is missing a statement by the attorney, use the following.) [Your submission is missing an attorney statement that he or she has the authority to represent the provider or supplier. [MAC Name] is requesting that you submit a rebuttal that includes an attorney statement that he or she has the authority to represent the provider or supplier within 15 calendar days of the date of this notice. If you do not timely respond to this request, your reconsideration submission may be dismissed.]

(If the submission is missing a signed written notice from the provider/supplier authorizing the representative to act on his/her/its behalf, use the following.) [Your submission is missing a written notice of the appointment of a representative signed by the provider or supplier. [MAC Name] is requesting that you submit written notice of the appointment of a representative that is signed by the provider or supplier within 15 calendar days of the date of this notice. If you do not timely respond to this request, your reconsideration submission may be dismissed.]

Your submission should be sent to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address]
[MAC Fax number]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

I. Favorable Reconsideration Request Model Letter in Response to an Enrollment Denial

(To be sent by hard-copy mail and email if email address is provided.
Optional to send via fax if a valid fax number is available).

[Month] [Day], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Reconsideration Request]
[Address] (Address from which the Reconsideration Request was sent)
[City], [State] [Zip Code]

Re: Reconsideration Request Decision
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXXX]
Reference Number: [XXXX] (optional)

Dear [Name of the Person(s) who submitted the Reconsideration Request]:

This letter is in response to the reconsideration request received by [MAC Name] based on an enrollment denial. The initial determination letter was dated [Month] [DD], [YYYY] and the reconsideration request was received by [MAC Name] on [Month] [DD], [YYYY]; therefore, this reconsideration request is considered timely. (if the reconsideration request is untimely, but good cause has been found to accept the reconsideration request, use the following [This reconsideration request was not timely submitted, but a good cause waiver has been granted.]) The following decision is based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

DENIAL REASON(S):

- 42 C.F.R. § 424.530(a)(denial reason 1-14)
- 42 C.F.R. § 424.530(a)(denial reason 1-14)

OTHER APPLICABLE AUTHORITIES:

- 42 C.F.R. §

- (Ex: Medicare Program Integrity Manual (MPIM) chapter 10, section 10.XX)

EXHIBITS:

- Exhibit 1: (Ex.: Reconsideration request, signed by Jane Doe, dated [Month] [DD] [YYYY].)
- Exhibit 2: (Ex: Copy of a medical license for Jane Doe from the Wisconsin Medical Board, effective [Month] [DD], [YYYY].)

(In this section list each document submitted by the provider or supplier. Each exhibit should include the date, as well as a brief description of the document. You shall also include all other documentation not submitted by the provider that the hearing officer reviewed in making the decision, e.g., enrollment applications, development letters, etc.)

BACKGROUND:

The documentation related to the matter for [Provider/Supplier Name] has been reviewed and the decision has been made in accordance with the applicable Medicare rules, policies and program instructions.

(Summarize the facts underlying the case which led up to the submission of the reconsideration request.)

RECONSIDERATION ANALYSIS:

(The hearing officer needs to check to determine if a CAP was also submitted and approved for this provider or supplier. If so, the reconsideration decision should only address the remaining authorities and use the following sentence, “[MAC Name] has approved the CAP submitted on [Month] [DD], [YYYY] in a decision dated [Month] [DD], [YYYY]. Therefore, this decision will only address the remaining denial reason(s) 42 C.F.R. § 424.530(a)(denial reason 1-14).)

(If the CAP resolves the denial in its entirety, the applicable moot model letter should be issued in response to the reconsideration request instead of this decision template.)

(A reconsideration request reviews whether or not an error was made at the time the initial determination was implemented. This section should summarize the statements made by the provider or supplier in its reconsideration request. Then conduct analysis of the arguments based on the applicable regulations and sub-regulations, MPIM. This section shall not reference a reconsideration decision without explaining how and why you came to that decision.)

DECISION:

(A short conclusory restatement.)

(Ex: On [Month] [DD], [YYYY], a disciplinary hearing was held regarding the medical license of Jane Doe. However, on [Month] [DD], [YYYY], the Wisconsin Medical Board declined to take disciplinary action against Jane Doe's medical license. As a result, [MAC Name] overturns the denial of Jane Doe's Medicare enrollment application as it relates to 42 C.F.R. § 424.530(a)(1).

This decision is a **FAVORABLE DECISION**. To effectuate this decision, [MAC name] will continue processing the enrollment application.

(If additional information is needed from the provider or supplier in order to reactivate the enrollment, the MAC shall state what information is needed from the provider or supplier in this reconsideration decision. MACs shall state that the requested information/documentation must be received within 30 calendar days of the date of this decision letter.)

**FURTHER APPEAL RIGHTS - ADMINISTRATIVE LAW
JUDGE (ALJ):**

If you are satisfied with this decision, you do not need to take further action. If you believe that this determination is not correct, you may request ALJ review for the reconsideration portion of this decision letter. To request ALJ review, you must file your appeal with the Civil Remedies Division of the Departmental Appeals Board within 60 calendar days after the date of receipt of this decision.

How to file a hearing request

You can file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at <https://dab.efile.hhs.gov/>.

To file a new appeal using DAB E-File, you first need to register a new account by:

1. Clicking Register on the DAB E-File home page;
2. Entering the information requested on the "Register New Account" form; and
3. Clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.

The e-mail address and password provided during registration must be entered on the login screen at https://dab.efile.hhs.gov/user_sessions/new to access DAB E-File. A registered user's access to DAB E-File is

restricted to the appeals for which he or she is a party or authorized representative.

Once registered, you may file your appeal by logging in and:

- Clicking the File New Appeal link on the Manage Existing Appeals screen, and then clicking Civil Remedies Division on the File New Appeal screen; and
- Entering and uploading the requested information and documents on the “File New Appeal – Civil Remedies Division” form.

All documents must be submitted in PDF form.

What you must include in a hearing request for ALJ review

At minimum, the Civil Remedies Division (CRD) requires a party to file the following:

- A signed request for hearing that:
 - Identifies the specific issues and the findings of fact and conclusions of law with which the party disagrees; and
 - Specifies the basis for contending that the findings and conclusions are incorrect;
- The underlying notice letter from CMS that sets forth the action taken and the party’s appeal rights.

In addition, the following identifying information is required with all ALJ hearing requests:

- Your legal business name
- Your Medicare PTAN (if applicable)
- Tax Identification Number (TIN) or Employer Identification Number (EIN)
- A copy of the Hearing Officer or the CMS Regional Office (RO) decision

The procedures for ALJ review can be found at Title 42 of the Code of Federal Regulations, sections 498.40 – 498.79.

Guidelines for Using DAB E-file

- Any document, including a request for hearing, will be deemed to have been filed on a given day if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day.
- A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-

related documents that CMS files, or CRD issues on behalf of the ALJ, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service.

- Parties are responsible for ensuring that DAB E-file email notifications do not go to their spam folders and that any spam filtering software they may have does not restrict their ability to receive emails from the system.
- More detailed instructions on DAB E-File for CRD cases can be found by clicking the CRD E- File Procedures link on the File New Appeal Screen for CRD appeals.

If you are unable to use DAB E-file

Parties are required to use DAB E-file unless they receive a waiver. If you cannot file your appeal electronically, you may mail your hearing request, along with a request for waiver of the electronic filing requirement and an explanation of why you cannot use DAB E-file, to: Department of Health and Human Services, Departmental Appeals Board, Civil Remedies Division, Mail Stop 6132, Attn: CMS Enrollment Appeal, 330 Independence Avenue, S.W., Cohen Building, Room G-644, Washington, D.C. 20201.

Appeal rights can be found 42 C.F.R. part 498. The regulation explains the appeal rights following the determination by the CMS as to whether such entities meet the requirements for enrollment in the Medicare program.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address]
[Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

J. Favorable Reconsideration Request Model Letter in Response to a Reactivation Effective Date Determination

(To be sent by hard-copy mail and email if email address is provided.)

Optional to send via fax if a valid fax number is available).

[Month] [Day], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of Reconsideration Request]

[Address] (Address from which the Reconsideration Request was sent)

[City], [State] [Zip Code]

Re: Reconsideration Request Decision

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)

NPI: [XXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXX] (optional)

Dear [Name of the person(s) who submitted the Reconsideration Request]:

This letter is in response to the reconsideration request received by [MAC Name] related to a reactivation effective date determination. The initial determination letter was dated [Month] [DD], [YYYY] and the reconsideration request was received by [MAC Name] on [Month] [DD], [YYYY]; therefore, this reconsideration request is considered timely. (if the reconsideration request is untimely, but good cause has been found to accept the reconsideration request, use the following [This reconsideration request was not timely submitted, but a good cause waiver has been granted.]) The following decision is based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

EFFECTIVE DATE REGULATION(S):

42 C.F.R. § 424.520(a-d) (Other effective date regulations may be included)

OTHER APPLICABLE AUTHORITIES:

42 C.F.R. § 424.540 (Other applicable regulations for MPIM sections may be included)

(Ex: Medicare Program Integrity Manual (MPIM) chapter 10, section 10.XX)

EXHIBITS:

Exhibit 1: (Ex.: CMS-855I Medicare enrollment application, signed and certified by John Smith on [Month] [DD], [YYYY].)

Exhibit 2: (Ex: Copy of an email chain between John Smith and Jane

Doe, dated [Month] [DD], [YYYY], requesting additional informed needed to process the revalidation application to completion for John Smith to Jane Doe.

(In this section list each document submitted by the provider or supplier. Each exhibit shall include the date, if provided, as well as a brief description of the document. You shall also include all other documentation not submitted by the provider that the hearing officer reviewed in making the decision, e.g., enrollment applications, development letters, etc.)

BACKGROUND:

The documentation related to the matter for [Provider/Supplier Name] has been reviewed and the decision has been made in accordance with the applicable Medicare rules, policies, and program instructions.

(Summarize the facts underlying the case which led up to the submission of the reconsideration request.)

RECONSIDERATION ANALYSIS:

(A reconsideration request reviews whether or not an error was made at the time the initial determination was implemented. This section should summarize the statements made by the provider or supplier in its reconsideration request. Then conduct analysis of the arguments based on the applicable regulations and sub-regulations, MPIM. This section shall not reference a reconsideration decision without explaining how and why you came to that decision.)

DECISION:

(A short conclusory restatement.)

(Ex.: On [Month] [DD], [YYYY], John Smith's revalidation application was approved with a gap in his billing privileges from [Month] [DD], [YYYY] to [Month] [DD], [YYYY]. However, as indicated above, [MAC Name] has determined that the reactivation effective should be [Month] [DD], [YYYY]. As a result of the change in the reactivation effective date, the gap in John Smith's Medicare billing privileges has been eliminated.)

This decision is a **FAVORABLE DECISION**. To effectuate this decision, [MAC name] [will modify/has modified] the reactivation effective date for [Provider/Supplier Name].

You must resubmit any claims that were denied or not previously

submitted due to the former gap in your Medicare billing privileges.

(If additional information is needed from the provider or supplier in order to reactivate the enrollment, the MAC shall state what information is needed from the provider or supplier in this reconsideration decision. MACs shall state that the requested information/documentation must be received within 30 calendar days of the date of this decision letter.)

FURTHER APPEAL RIGHTS - ADMINISTRATIVE LAW JUDGE (ALJ):

If you are satisfied with this decision, you do not need to take further action. If you believe that this determination is not correct, you may request ALJ review for the reconsideration portion of this decision letter. To request ALJ review, you must file your appeal with the Civil Remedies Division of the Departmental Appeals Board within 60 calendar days after the date of receipt of this decision.

How to file a hearing request

You can file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at <https://dab.efile.hhs.gov/>.

To file a new appeal using DAB E-File, you first need to register a new account by:

1. Clicking Register on the DAB E-File home page;
2. Entering the information requested on the “Register New Account” form; and
3. Clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.

The e-mail address and password provided during registration must be entered on the login screen at https://dab.efile.hhs.gov/user_sessions/new to access DAB E-File. A registered user’s access to DAB E-File is restricted to the appeals for which he or she is a party or authorized representative.

Once registered, you may file your appeal by logging in and:

- Clicking the File New Appeal link on the Manage Existing Appeals screen, and then clicking Civil Remedies Division on the File New Appeal screen; and
- Entering and uploading the requested information and documents

on the “File New Appeal – Civil Remedies Division” form.

All documents must be submitted in PDF form.

What you must include in a hearing request for ALJ review

At minimum, the Civil Remedies Division (CRD) requires a party to file the following:

- A signed request for hearing that:
 - Identifies the specific issues and the findings of fact and conclusions of law with which the party disagrees; and
 - Specifies the basis for contending that the findings and conclusions are incorrect;
- The underlying notice letter from CMS that sets forth the action taken and the party’s appeal rights.

In addition, the following identifying information is required with all ALJ hearing requests:

- Your legal business name
- Your Medicare PTAN (if applicable)
- Tax Identification Number (TIN) or Employer Identification Number (EIN)
- A copy of the Hearing Officer or the CMS Regional Office (RO) decision

The procedures for ALJ review can be found at Title 42 of the Code of Federal Regulations, sections 498.40 – 498.79.

Guidelines for Using DAB E-file

- Any document, including a request for hearing, will be deemed to have been filed on a given day if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day.
- A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the ALJ, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service.
- Parties are responsible for ensuring that DAB E-file email notifications do not go to their spam folders and that any spam filtering software they may have does not restrict their ability to receive emails from the system.
- More detailed instructions on DAB E-File for CRD cases can be

found by clicking the CRD E- File Procedures link on the File New Appeal Screen for CRD appeals.

If you are unable to use DAB E-file

Parties are required to use DAB E-file unless they receive a waiver. If you cannot file your appeal electronically, you may mail your hearing request, along with a request for waiver of the electronic filing requirement and an explanation of why you cannot use DAB E-file, to: Department of Health and Human Services, Departmental Appeals Board, Civil Remedies Division, Mail Stop 6132, Attn: CMS Enrollment Appeal, 330 Independence Avenue, S.W., Cohen Building, Room G-644, Washington, D.C. 20201.

Appeal rights can be found 42 C.F.R. part 498. The regulation explains the appeal rights following the determination by the CMS as to whether such entities meet the requirements for enrollment in the Medicare program.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address]
[Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

K. Favorable Reconsideration Request Model Letter in Response to an Effective Date of Participation Determination (Non-Revalidation)

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [Day], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Reconsideration Request]
[Address] (Address from which the Reconsideration Request was sent)
[City], [State] [Zip Code]

Re: Reconsideration Request Decision

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)

NPI: [XXXXXXXXXXXX]
PTAN: [XXXXXX]
Reference Number: [XXXX] (optional)

Dear [Name of the person(s) who submitted the Reconsideration Request]:

This letter is in response to the reconsideration request received by [MAC Name] in response to a determination of the effective date of participation in the Medicare program. The initial determination letter was dated [Month] [DD], [YYYY] and the reconsideration request was received by [MAC Name] on [Month] [DD], [YYYY]; therefore, this reconsideration request is considered timely. (if the reconsideration request is untimely, but good cause has been found to accept the reconsideration request, use the following [This reconsideration request was not timely submitted, but a good cause waiver has been granted.]) The following decision is based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

EFFECTIVE DATE REGULATION(S):

42 C.F.R. § 424.520(a-d)

OTHER APPLICABLE AUTHORITIES:

42 C.F.R. §
(Ex: Medicare Program Integrity Manual (MPIM) chapter 10, section 10.XX)

EXHIBITS:

Exhibit 1: (Ex.: CMS-855I Medicare enrollment application, signed and certified by John Smith on [Month] [DD], [YYYY].)

Exhibit 2: (Ex: Copy of an email chain between John Smith and Jane Doe, dated [Month] [DD], [YYYY], submitting the requested development documentation for John Smith to Jane Doe.

(In this section list each document submitted by the provider or supplier. Each exhibit should include the date, as well as a brief description of the document. You shall also include all other documentation not submitted by the provider that the hearing officer reviewed in making the decision, e.g., enrollment applications, development letters, etc.)

BACKGROUND:

The documentation related to the matter for [Provider/Supplier Name] has been reviewed and the decision has been made in accordance with the applicable Medicare rules, policies, and program instructions.

(Summarize the facts underlying the case which led up to the determination of the effective date.)

RECONSIDERATION ANALYSIS:

(A reconsideration request reviews whether or not an error was made at the time the initial determination was implemented. This section should summarize the statements made by the provider or supplier in its reconsideration request. Then conduct analysis of the arguments based on the applicable regulations and sub-regulations, MPIM. This section shall not reference a reconsideration decision without explaining how and why you came to that decision.)

DECISION:

(A short conclusory restatement.)

(On [Month] [DD], [YYYY], John Smith submitted an initial enrollment application, which was subsequently rejected for failure to timely respond to a development request for additional information/documentation. As part of his reconsideration request, John Smith submitted an email receipt showing that he timely responded to the development request. As a result, [MAC Name] will modify John Smith's Medicare effective date to [Month] [DD], [YYYY].)

This decision is a **FAVORABLE DECISION**. To effectuate this decision, [MAC name] [will modify/has modified] the enrollment effective date to [Month] [DD], [YYYY].

(If additional information is needed from the provider or supplier in order to reactivate the enrollment, the MAC shall state what information is needed from the provider or supplier in this reconsideration decision. MACs shall state that the requested information/documentation must be received within 30 calendar days of the date of this decision letter.)

FURTHER APPEAL RIGHTS - ADMINISTRATIVE LAW JUDGE (ALJ):

If you are satisfied with this decision, you do not need to take further action. If you believe that this determination is not correct, you may request ALJ review for the reconsideration portion of this decision letter. To request ALJ review, you must file your appeal with the Civil Remedies Division of the Departmental Appeals Board within 60 calendar days after the date of receipt of this decision.

How to file a hearing request

You can file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at <https://dab.efile.hhs.gov/>.

To file a new appeal using DAB E-File, you first need to register a new account by:

1. Clicking Register on the DAB E-File home page;
2. Entering the information requested on the “Register New Account” form; and
3. Clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.

The e-mail address and password provided during registration must be entered on the login screen at https://dab.efile.hhs.gov/user_sessions/new to access DAB E-File. A registered user’s access to DAB E-File is restricted to the appeals for which he or she is a party or authorized representative.

Once registered, you may file your appeal by logging in and:

- Clicking the File New Appeal link on the Manage Existing Appeals screen, and then clicking Civil Remedies Division on the File New Appeal screen; and
- Entering and uploading the requested information and documents on the “File New Appeal – Civil Remedies Division” form.

All documents must be submitted in PDF form.

What you must include in a hearing request for ALJ review

At minimum, the Civil Remedies Division (CRD) requires a party to file the following:

- A signed request for hearing that:
 - Identifies the specific issues and the findings of fact and conclusions of law with which the party disagrees; and
 - Specifies the basis for contending that the findings and conclusions are incorrect;
- The underlying notice letter from CMS that sets forth the action taken and the party’s appeal rights.

In addition, the following identifying information is required with all ALJ hearing requests:

- Your legal business name
- Your Medicare PTAN (if applicable)
- Tax Identification Number (TIN) or Employer Identification Number (EIN)
- A copy of the Hearing Officer or the CMS Regional Office (RO) decision

The procedures for ALJ review can be found at Title 42 of the Code of Federal Regulations, sections 498.40 – 498.79.

Guidelines for Using DAB E-file

- Any document, including a request for hearing, will be deemed to have been filed on a given day if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day.
- A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the ALJ, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service.
- Parties are responsible for ensuring that DAB E-file email notifications do not go to their spam folders and that any spam filtering software they may have does not restrict their ability to receive emails from the system.
- More detailed instructions on DAB E-File for CRD cases can be found by clicking the CRD E- File Procedures link on the File New Appeal Screen for CRD appeals.

If you are unable to use DAB E-file

Parties are required to use DAB E-file unless they receive a waiver. If you cannot file your appeal electronically, you may mail your hearing request, along with a request for waiver of the electronic filing requirement and an explanation of why you cannot use DAB E-file, to: Department of Health and Human Services, Departmental Appeals Board, Civil Remedies Division, Mail Stop 6132, Attn: CMS Enrollment Appeal, 330 Independence Avenue, S.W., Cohen Building, Room G-644, Washington, D.C. 20201.

Appeal rights can be found 42 C.F.R. part 498. The regulation explains the appeal rights following the determination by the CMS as to whether such entities meet the requirements for enrollment in the Medicare program.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address]
[Call Center Telephone Number]
Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

L. Favorable Reconsideration Request Model Letter for Revocation Determination

(To be sent by hard-copy mail and email if email address is provided.
Optional to send via fax if a valid fax number is available).

[Month] [Day], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Reconsideration Request]
[Address] (Address from which the Reconsideration Request was sent)
[City], [State] [Zip Code]

Re: Reconsideration Request Decision
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

Dear [Person(s) who submitted the Reconsideration Request]:

This letter is in response to the reconsideration request received by [MAC Name] based on a revocation of Medicare billing privileges. The initial determination letter was dated [Month] [DD], [YYYY] and the reconsideration request was received by [MAC Name] on [Month] [DD], [YYYY]; therefore, this appeal is considered timely. (if the reconsideration request is untimely, but good cause has been found to accept the reconsideration request, use the following [This reconsideration request was not timely submitted, but a good cause waiver has been granted.]) The following decision is based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

REVOCATION REASON(S):

42 C.F.R. § 424.535(a)(revocation reason 1-22)

42 C.F.R. § 424.535(a)(revocation reason 1-22)

OTHER APPLICABLE AUTHORITIES:

42 C.F.R. §

(Ex: Medicare Program Integrity Manual chapter 10, section 10.XX)

EXHIBITS:

Exhibit 1: (Ex.: Reconsideration request, signed by Jane Doe, dated [Month] [DD] [YYYY].)

Exhibit 2: (Ex: Copy of a medical license for Jane Doe from the Wisconsin Medical Board, effective [Month] [DD], [YYYY].)

(In this section list each document submitted by the provider or supplier. Each exhibit should include the date, as well as a brief description of the document. You shall also include all other documentation not submitted by the provider that the hearing officer reviewed in making the decision, e.g., enrollment applications, development letters, etc.)

BACKGROUND:

The documentation related to the matter for [Provider/Supplier Name] has been reviewed and the decision has been made in accordance with the applicable Medicare rules, policies, and program instructions.

(Summarize the facts underlying the case which led up to the submission of the reconsideration request.)

RECONSIDERATION ANALYSIS:

(The hearing officer needs to check to determine if a CAP was also submitted and approved for this provider or supplier. If so, the reconsideration decision should only address the remaining authorities and use the following sentence, “[MAC Name] has reviewed and/or approved the CAP submitted on [Month] [DD], [YYYY] in a decision dated [Month] [DD], [YYYY].

Therefore, this decision will only address the remaining revocation reason(s) 42 C.F.R. § 424.535(a)(revocation reason 1- 22).)

(If the CAP resolves the revocation in its entirety, the applicable moot model letter should be issued in response to the reconsideration request instead of this decision template.)

(A reconsideration request reviews whether or not an error was made at the time the initial determination was implemented. This section should summarize the statements made by the provider or supplier in its

reconsideration request. Then conduct analysis of the provider or supplier arguments based on the applicable regulations and sub-regulations (MPIM). This section shall not reference a reconsideration decision without explaining how and why you came to that decision.)

DECISION:

(A short conclusory restatement.)

(Ex: On [Month] [DD], [YYYY], Jane Doe's medical license was temporarily suspended by the Wisconsin medical board based on allegations of malpractice. However, on [Month] [DD] [YYYY], the Wisconsin medical board issued an order reversing the license suspension back to its implementation date based on the outcome of a hearing. As a result, [MAC Name] is overturning the revocation of Jane Doe's Medicare billing privileges as it relates to 42 C.F.R. § 424.535(a)(1).

This decision is a **FAVORABLE DECISION**. To effectuate this decision, [MAC name] [will reinstate/has reinstated] your Medicare billing privileges, effective [Month] [DD], [YYYY].

(The reinstatement date is based on chapter 10 of the MPIM and the date of the provider's or supplier's revocation or the date the provider's or supplier's license was reinstated if the revocation involves a licensure issue.)

(If additional information is needed from the provider or supplier in order to reactivate the enrollment, the MAC shall state what information is needed from the provider or supplier in this reconsideration decision. MACs shall state that the requested information/documentation must be received within 30 calendar days of the date of this decision letter.)

FURTHER APPEAL RIGHTS - ADMINISTRATIVE LAW JUDGE (ALJ):

If you are satisfied with this decision, you do not need to take further action. If you believe that this determination is not correct, you may request ALJ review for the reconsideration portion of this decision letter. To request ALJ review, you must file your appeal with the Civil Remedies Division of the Departmental Appeals Board within 60 calendar days after the date of receipt of this decision.

How to file a hearing request

You can file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at

<https://dab.efile.hhs.gov/>.

To file a new appeal using DAB E-File, you first need to register a new account by:

1. Clicking Register on the DAB E-File home page;
2. Entering the information requested on the “Register New Account” form; and
3. Clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.

The e-mail address and password provided during registration must be entered on the login screen at https://dab.efile.hhs.gov/user_sessions/new to access DAB E-File. A registered user’s access to DAB E-File is restricted to the appeals for which he or she is a party or authorized representative.

Once registered, you may file your appeal by logging in and:

- Clicking the File New Appeal link on the Manage Existing Appeals screen, and then clicking Civil Remedies Division on the File New Appeal screen; and
- Entering and uploading the requested information and documents on the “File New Appeal – Civil Remedies Division” form.

All documents must be submitted in PDF form.

What you must include in a hearing request for ALJ review

At minimum, the Civil Remedies Division (CRD) requires a party to file the following:

- A signed request for hearing that:
 - Identifies the specific issues and the findings of fact and conclusions of law with which the party disagrees; and
 - Specifies the basis for contending that the findings and conclusions are incorrect;
- The underlying notice letter from CMS that sets forth the action taken and the party’s appeal rights.

In addition, the following identifying information is required with all ALJ hearing requests:

- Your legal business name
- Your Medicare PTAN (if applicable)
- Tax Identification Number (TIN) or Employer Identification

- Number (EIN)
- A copy of the Hearing Officer or the CMS Regional Office (RO) decision

The procedures for ALJ review can be found at Title 42 of the Code of Federal Regulations, sections 498.40 – 498.79.

Guidelines for Using DAB E-file

- Any document, including a request for hearing, will be deemed to have been filed on a given day if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day.
- A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the ALJ, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service.
- Parties are responsible for ensuring that DAB E-file email notifications do not go to their spam folders and that any spam filtering software they may have does not restrict their ability to receive emails from the system.
- More detailed instructions on DAB E-File for CRD cases can be found by clicking the CRD E- File Procedures link on the File New Appeal Screen for CRD appeals.

If you are unable to use DAB E-file

Parties are required to use DAB E-file unless they receive a waiver. If you cannot file your appeal electronically, you may mail your hearing request, along with a request for waiver of the electronic filing requirement and an explanation of why you cannot use DAB E-file, to: Department of Health and Human Services, Departmental Appeals Board, Civil Remedies Division, Mail Stop 6132, Attn: CMS Enrollment Appeal, 330 Independence Avenue, S.W., Cohen Building, Room G-644, Washington, D.C. 20201.

Appeal rights can be found 42 C.F.R. part 498. The regulation explains the appeal rights following the determination by the CMS as to whether such entities meet the requirements for enrollment in the Medicare program.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address]
[Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

M. Unfavorable Reconsideration Request Model Letter in Response to an Enrollment Denial

(To be sent by hard-copy mail and email if email address is provided.
Optional to send via fax if a valid fax number is available).

[Month] [Day], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Reconsideration Request]
[Address] (Address from which the Reconsideration Request was sent)
[City], [State] [Zip Code]

Re: Reconsideration Request Decision
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXXX]
Reference Number: [XXXX] (optional)

Dear [Person(s) who submitted the Reconsideration Request]:

This letter is in response to the reconsideration request received by [MAC Name] based on an enrollment denial. The initial determination letter was dated [Month] [DD], [YYYY] and the reconsideration request was received by [MAC Name] on [Month] [DD], [YYYY]; therefore, this appeal is considered timely. (if the reconsideration request is untimely, but good cause has been found to accept the reconsideration request, use the following [This reconsideration request was not timely submitted, but a good cause waiver has been granted.]) The following decision is based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

DENIAL REASON(S):

42 C.F.R. § 424.530(a)(denial reason 1-14)

42 C.F.R. § 424.530(a)(denial reason 1-14)

OTHER APPLICABLE AUTHORITIES:

42 C.F.R. §

(Ex: Medicare Program Integrity Manual chapter 10, section 10.XX)

EXHIBITS:

Exhibit 1: (Ex.: Reconsideration request, signed by Jane Doe, dated [Month] [DD] [YYYY].)

Exhibit 2: (Ex: Copy of a medical license for Jane Doe from the Wisconsin Medical Board, effective [Month] [DD], [YYYY].)

(In this section list each document submitted by the provider or supplier. Each exhibit should include the date, as well as a brief description of the document. You shall also include all other documentation not submitted by the provider that the hearing officer reviewed in making the decision, e.g., enrollment applications, development letters, etc.)

BACKGROUND:

The documentation related to the matter for [Provider/Supplier Name] has been reviewed and the decision has been made in accordance with the applicable Medicare rules, policies, and program instructions.

[Summarize the facts underlying the case which led up to the submission of the reconsideration request.]

RECONSIDERATION ANALYSIS:

(The hearing officer needs to check to determine if a CAP was also submitted and approved for this provider or supplier. If so, the reconsideration decision should only address the remaining authorities and use the following sentence, “[MAC Name] has approved the CAP submitted on [Month] [DD], [YYYY] in a decision dated [Month] [DD], [YYYY]. Therefore, this decision will only address the remaining denial reason(s) 42 C.F.R. § 424.530(a)(denial reason 1-14).)

(If the CAP resolves the denial in its entirety, the applicable moot model letter should be issued in response to the reconsideration request instead of this decision template.)

(A reconsideration request reviews whether or not an error was made at the time the initial determination was implemented. This section should summarize the statements made by the provider or supplier in its reconsideration request. Then conduct analysis of the arguments based on the applicable regulations and sub-regulations (MPIM). This section shall not reference a reconsideration decision without explaining how and why

you came to that decision.)

DECISION:

(A short conclusory restatement.)

(Ex: On [Month] [DD], [YYYY], Jane Doe's medical license was temporarily suspended by the Wisconsin medical board based on allegations of malpractice. Jane Doe did not submit any documentation to demonstrate that her medical license was not suspended. In addition, [MAC Name] has confirmed that Jane Doe's medical license remains suspended. As a result, [MAC Name] upholds the denial of Jane Doe's Medicare enrollment application as it relates to 42 C.F.R. § 424.530(a)(1).)

This decision is an **UNFAVORABLE DECISION**. [MAC name] concludes that there was no error made in the denial of your Medicare enrollment. As a result, the denial of your Medicare enrollment is upheld.

FURTHER APPEAL RIGHTS - ADMINISTRATIVE LAW JUDGE (ALJ):

If you are satisfied with this decision, you do not need to take further action. If you believe that this determination is not correct, you may request ALJ review for the reconsideration portion of this decision letter. To request ALJ review, you must file your appeal with the Civil Remedies Division of the Departmental Appeals Board within 60 calendar days after the date of receipt of this decision.

How to file a hearing request

You can file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at <https://dab.efile.hhs.gov/>.

To file a new appeal using DAB E-File, you first need to register a new account by:

1. Clicking Register on the DAB E-File home page;
2. Entering the information requested on the "Register New Account" form; and
3. Clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.

The e-mail address and password provided during registration must be entered on the login screen at https://dab.efile.hhs.gov/user_sessions/new to access DAB E-File. A registered user's access to DAB E-File is

restricted to the appeals for which he or she is a party or authorized representative.

Once registered, you may file your appeal by logging in and:

- Clicking the File New Appeal link on the Manage Existing Appeals screen, and then clicking Civil Remedies Division on the File New Appeal screen; and
- Entering and uploading the requested information and documents on the “File New Appeal – Civil Remedies Division” form.

All documents must be submitted in PDF form.

What you must include in a hearing request for ALJ review

At minimum, the Civil Remedies Division (CRD) requires a party to file the following:

- A signed request for hearing that:
 - Identifies the specific issues and the findings of fact and conclusions of law with which the party disagrees; and
 - Specifies the basis for contending that the findings and conclusions are incorrect;
- The underlying notice letter from CMS that sets forth the action taken and the party’s appeal rights.

In addition, the following identifying information is required with all ALJ hearing requests:

- Your legal business name
- Your Medicare PTAN (if applicable)
- Tax Identification Number (TIN) or Employer Identification Number (EIN)
- A copy of the Hearing Officer or the CMS Regional Office (RO) decision

The procedures for ALJ review can be found at Title 42 of the Code of Federal Regulations, sections 498.40 – 498.79.

Guidelines for Using DAB E-file

- Any document, including a request for hearing, will be deemed to have been filed on a given day if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day.

- A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the ALJ, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service.
- Parties are responsible for ensuring that DAB E-file email notifications do not go to their spam folders and that any spam filtering software they may have does not restrict their ability to receive emails from the system.
- More detailed instructions on DAB E-File for CRD cases can be found by clicking the CRD E- File Procedures link on the File New Appeal Screen for CRD appeals.

If you are unable to use DAB E-file

Parties are required to use DAB E-file unless they receive a waiver. If you cannot file your appeal electronically, you may mail your hearing request, along with a request for waiver of the electronic filing requirement and an explanation of why you cannot use DAB E-file, to: Department of Health and Human Services, Departmental Appeals Board, Civil Remedies Division, Mail Stop 6132, Attn: CMS Enrollment Appeal, 330 Independence Avenue, S.W., Cohen Building, Room G-644, Washington, D.C. 20201.

Appeal rights can be found 42 C.F.R. part 498. The regulation explains the appeal rights following the determination by the CMS as to whether such entities meet the requirements for enrollment in the Medicare program.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address]
[Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

N. Unfavorable Reconsideration Request Model Letter in Response to a Reactivation Effective Date Determination

(To be sent by hard-copy mail and email if email address is provided.
Optional to send via fax if a valid fax number is available).

[Month] [Day], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of Reconsideration Request]

[Address] (Address from which the Reconsideration Request was sent)

[City], [State] [Zip Code]

Re: Reconsideration Request Decision

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)

NPI: [XXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXX] (optional)

Dear [Name of the person(s) who submitted the Reconsideration Request]:

This letter is in response to the reconsideration request received by [MAC Name] in response to a reactivation effective date determination. The initial determination letter was dated [Month] [DD], [YYYY] and the reconsideration request was received by [MAC Name] on [Month] [DD], [YYYY]; therefore, this appeal is considered timely. (if the reconsideration request is untimely, but good cause has been found to accept the reconsideration request, use the following [This reconsideration request was not timely submitted, but a good cause waiver has been granted.]) The following decision is based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

EFFECTIVE DATE REGULATION(S):

42 C.F.R. § 424.520(a-d) (Other effective date regulations may be included)

OTHER APPLICABLE AUTHORITIES:

42 C.F.R. § 424.540 (Other applicable regulations for MPIM sections may be included)

(Ex: Medicare Program Integrity Manual (MPIM) chapter 10, section 10.XX)

EXHIBITS:

Exhibit 1: (Ex.: CMS-855I Medicare enrollment application, signed and certified by John Smith on [Month] [DD], [YYYY].)

Exhibit 2: (Ex: Copy of an email chain between John Smith and Jane Doe, dated [Month] [DD], [YYYY], submitting the requested development documentation for John Smith to Jane Doe.)

(In this section list each document submitted by the provider or supplier. Each exhibit should include the date, as well as a brief description of the document. You shall also include all other documentation not submitted by the provider that the hearing officer reviewed in making the decision, e.g., enrollment applications, development letters, etc.)

BACKGROUND:

The documentation related to the matter for [Provider/Supplier Name] has been reviewed and the decision has been made in accordance with the applicable Medicare rules, policies, and program instructions.

(Summarize the facts underlying the case which led up to the submission of the reconsideration request.)

RECONSIDERATION ANALYSIS:

(A reconsideration request reviews whether or not an error was made at the time the initial determination was implemented. This section should summarize the statements made by the provider or supplier in its reconsideration request. Then conduct analysis of the arguments based on the applicable regulations and sub-regulations, MPIM. This section shall not reference a reconsideration decision without explaining how and why you came to that decision.)

DECISION:

(A short conclusory restatement.)

(On [Month] [DD], [YYYY], John Smith's Medicare enrollment was deactivated for failing to timely respond to a revalidation request. On [Month] [DD], [YYYY], John Smith submitted a revalidation application, which was processed and approved. Per the MPIM, Ch. 10, Section 10.4(K), John Smith's Medicare enrollment was reactivated, but with a gap in his Medicare billing privileges from [Month] [DD], [YYYY] to [Month] [DD], [YYYY]. John Smith's reconsideration request did not demonstrate an error in the determination of his reactivation effective date.)

This decision is an **UNFAVORABLE DECISION**. [MAC name] concludes that no error was made in the determination of a reactivation effective date resulting in a gap in your Medicare billing privileges. As a result, your reactivation effective date will remain [Month] [DD]

[YYYY].

FURTHER APPEAL RIGHTS - ADMINISTRATIVE LAW JUDGE (ALJ):

If you are satisfied with this decision, you do not need to take further action. If you believe that this determination is not correct, you may request ALJ review for the reconsideration portion of this decision letter. To request ALJ review, you must file your appeal with the Civil Remedies Division of the Departmental Appeals Board within 60 calendar days after the date of receipt of this decision.

How to file a hearing request

You can file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at <https://dab.efile.hhs.gov/>.

To file a new appeal using DAB E-File, you first need to register a new account by:

1. Clicking Register on the DAB E-File home page;
2. Entering the information requested on the “Register New Account” form; and
3. Clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.

The e-mail address and password provided during registration must be entered on the login screen at https://dab.efile.hhs.gov/user_sessions/new to access DAB E-File. A registered user’s access to DAB E-File is restricted to the appeals for which he or she is a party or authorized representative.

Once registered, you may file your appeal by logging in and:

- Clicking the File New Appeal link on the Manage Existing Appeals screen, and then clicking Civil Remedies Division on the File New Appeal screen; and
- Entering and uploading the requested information and documents on the “File New Appeal – Civil Remedies Division” form.

All documents must be submitted in PDF form.

What you must include in a hearing request for ALJ review

At minimum, the Civil Remedies Division (CRD) requires a party to file

the following:

- A signed request for hearing that:
 - Identifies the specific issues and the findings of fact and conclusions of law with which the party disagrees; and
 - Specifies the basis for contending that the findings and conclusions are incorrect;
- The underlying notice letter from CMS that sets forth the action taken and the party's appeal rights.

In addition, the following identifying information is required with all ALJ hearing requests:

- Your legal business name
- Your Medicare PTAN (if applicable)
- Tax Identification Number (TIN) or Employer Identification Number (EIN)
- A copy of the Hearing Officer or the CMS Regional Office (RO) decision

The procedures for ALJ review can be found at Title 42 of the Code of Federal Regulations, sections 498.40 – 498.79.

Guidelines for Using DAB E-file

- Any document, including a request for hearing, will be deemed to have been filed on a given day if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day.
- A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the ALJ, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service.
- Parties are responsible for ensuring that DAB E-file email notifications do not go to their spam folders and that any spam filtering software they may have does not restrict their ability to receive emails from the system.
- More detailed instructions on DAB E-File for CRD cases can be found by clicking the CRD E- File Procedures link on the File New Appeal Screen for CRD appeals.

If you are unable to use DAB E-file

Parties are required to use DAB E-file unless they receive a waiver. If you cannot file your appeal electronically, you may mail your hearing

request, along with a request for waiver of the electronic filing requirement and an explanation of why you cannot use DAB E-file, to: Department of Health and Human Services, Departmental Appeals Board, Civil Remedies Division, Mail Stop 6132, Attn: CMS Enrollment Appeal, 330 Independence Avenue, S.W., Cohen Building, Room G-644, Washington, D.C. 20201.

Appeal rights can be found 42 C.F.R. part 498. The regulation explains the appeal rights following the determination by the CMS as to whether such entities meet the requirements for enrollment in the Medicare program.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address]
[Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

O. Unfavorable Reconsideration Request Model Letter in Response to an Effective Date of Participation Determination (Non-Revalidation)

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [Day], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Reconsideration Request]
[Address] (Address from which the Reconsideration Request was sent)
[City], [State] [Zip Code]

Re: Reconsideration Request Decision
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

Dear [Person(s) who submitted the Reconsideration Request]:

This letter is in response to the reconsideration request received by [MAC Name] based on an effective date of enrollment determination. The initial determination letter was dated [Month] [DD], [YYYY] and the reconsideration request was received by [MAC Name] on [Month] [DD], [YYYY]; therefore, this appeal is considered timely. (if the reconsideration request is untimely, but good cause has been found to accept the reconsideration request, use the following [This reconsideration request was not timely submitted, but a good cause waiver has been granted.]) The following decision is based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

EFFECTIVE DATE REGULATION(S):

42 C.F.R. § 424.520(a-d)

OTHER APPLICABLE AUTHORITIES:

42 C.F.R. §
(Ex: Medicare Program Integrity Manual chapter 10, section 10.XX)

EXHIBITS:

Exhibit 1: (Ex.: CMS-855I Medicare enrollment application, signed and certified by John Smith on [Month] [DD], [YYYY].)
Exhibit 2: (Ex: Copy of an email chain between John Smith and Jane Doe, dated [Month] [DD], [YYYY], submitting the requested development documentation for John Smith to Jane Doe.)

(In this section list each document submitted by the provider or supplier. Each exhibit should include the date, as well as a brief description of the document. You shall also include all other documentation not submitted by the provider that the hearing officer reviewed in making the decision, e.g., enrollment applications, development letters, etc.)

BACKGROUND:

The documentation related to the matter for [Provider/Supplier Name] has been reviewed and the decision has been made in accordance with the applicable Medicare rules, policies, and program instructions.

(Summarize the facts underlying the case which led up to the submission of the reconsideration request.)

RECONSIDERATION ANALYSIS:

(A reconsideration request reviews whether or not an error was made at

the time the initial determination was implemented. This section should summarize the statements made by the provider or supplier in its reconsideration request. Then conduct analysis of the arguments based on the applicable regulations and sub-regulations (MPIM). This section shall not reference a reconsideration decision without explaining how and why you came to that decision.)

DECISION:

(A short conclusory restatement.)

(On [Month] [DD], [YYYY], John Smith submitted an initial Medicare enrollment application. On [Month] [DD], [YYYY], [MAC Name] sent a development request to John Smith for additional documentation/information to continue processing his enrollment application.

However, John Smith did not submit the requested documentation within 30 days. As a result, [MAC Name] properly rejected John Smith's Medicare enrollment application received on [Month] [DD] [YYYY]. On [Month] [DD] [YYYY], John Smith submitted another Medicare enrollment application, which was processed and subsequently approved with an effective date of [Month] [DD], [YYYY] in accordance with 42 C.F.R. § 424.520.

This decision is an **UNFAVORABLE DECISION**. [MAC name] concludes that no error was made in the determination of your effective date of participation in the Medicare program. As a result, the effective date of participation will remain the same.

FURTHER APPEAL RIGHTS - ADMINISTRATIVE LAW JUDGE (ALJ):

If you are satisfied with this decision, you do not need to take further action. If you believe that this determination is not correct, you may request ALJ review for the reconsideration portion of this decision letter. To request ALJ review, you must file your appeal with the Civil Remedies Division of the Departmental Appeals Board within 60 calendar days after the date of receipt of this decision.

How to file a hearing request

You can file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at <https://dab.efile.hhs.gov/>.

To file a new appeal using DAB E-File, you first need to register a new account by:

1. Clicking Register on the DAB E-File home page;
2. Entering the information requested on the “Register New Account” form; and
3. Clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.

The e-mail address and password provided during registration must be entered on the login screen at https://dab.efile.hhs.gov/user_sessions/new to access DAB E-File. A registered user’s access to DAB E-File is restricted to the appeals for which he or she is a party or authorized representative.

Once registered, you may file your appeal by logging in and:

- Clicking the File New Appeal link on the Manage Existing Appeals screen, and then clicking Civil Remedies Division on the File New Appeal screen; and
- Entering and uploading the requested information and documents on the “File New Appeal – Civil Remedies Division” form.

All documents must be submitted in PDF form.

What you must include in a hearing request for ALJ review

At minimum, the Civil Remedies Division (CRD) requires a party to file the following:

- A signed request for hearing that:
 - Identifies the specific issues and the findings of fact and conclusions of law with which the party disagrees; and
 - Specifies the basis for contending that the findings and conclusions are incorrect;
- The underlying notice letter from CMS that sets forth the action taken and the party’s appeal rights.

In addition, the following identifying information is required with all ALJ hearing requests:

- Your legal business name
- Your Medicare PTAN (if applicable)
- Tax Identification Number (TIN) or Employer Identification Number (EIN)
- A copy of the Hearing Officer or the CMS Regional Office (RO) decision

The procedures for ALJ review can be found at Title 42 of the Code of Federal Regulations, sections 498.40 – 498.79.

Guidelines for Using DAB E-file

- Any document, including a request for hearing, will be deemed to have been filed on a given day if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day.
- A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the ALJ, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service.
- Parties are responsible for ensuring that DAB E-file email notifications do not go to their spam folders and that any spam filtering software they may have does not restrict their ability to receive emails from the system.
- More detailed instructions on DAB E-File for CRD cases can be found by clicking the CRD E- File Procedures link on the File New Appeal Screen for CRD appeals.

If you are unable to use DAB E-file

Parties are required to use DAB E-file unless they receive a waiver. If you cannot file your appeal electronically, you may mail your hearing request, along with a request for waiver of the electronic filing requirement and an explanation of why you cannot use DAB E-file, to: Department of Health and Human Services, Departmental Appeals Board, Civil Remedies Division, Mail Stop 6132, Attn: CMS Enrollment Appeal, 330 Independence Avenue, S.W., Cohen Building, Room G-644, Washington, D.C. 20201.

Appeal rights can be found 42 C.F.R. part 498. The regulation explains the appeal rights following the determination by the CMS as to whether such entities meet the requirements for enrollment in the Medicare program.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address]
[Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

P. Unfavorable Reconsideration Request Model Letter for Revocation Determination

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [Day], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Reconsideration Request]
[Address] (Address from which the Reconsideration Request was sent)
[City], [State] [Zip Code]

Re: Reconsideration Request Decision
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXXXX]
PTAN: [XXXXXX]
Reference Number: [XXXX] (optional)

Dear [Person(s) who submitted the Reconsideration Request]:

This letter is in response to the reconsideration request received by [MAC Name] based on a revocation of Medicare billing privileges. The initial determination letter was dated [Month] [DD], [YYYY] and the reconsideration request was received by [MAC Name] on [Month] [DD], [YYYY]; therefore, this appeal is considered timely. (if the reconsideration request is untimely, but good cause has been found to accept the reconsideration request, use the following [This reconsideration request was not timely submitted, but a good cause waiver has been granted.]) The following decision is based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

REVOCATION REASON(S):

42 C.F.R. § 424.535(a)(revocation reason 1-22)
42 C.F.R. § 424.535(a)(revocation reason 1-22)

OTHER APPLICABLE AUTHORITIES:

42 C.F.R. §
(Ex: Medicare Program Integrity Manual chapter 10, section 10.XX)

EXHIBITS:

Exhibit 1: (Ex.: Reconsideration request, signed by Jane Doe, dated [Month] [DD] [YYYY].)

Exhibit 2: (Ex: Copy of a medical license for Jane Doe from the Wisconsin Medical Board, effective [Month] [DD], [YYYY].)

(In this section list each document submitted by the provider or supplier. Each exhibit should include the date, as well as a brief description of the document. You shall also include all other documentation not submitted by the provider that the hearing officer reviewed in making the decision, e.g., enrollment applications, development letters, etc.)

BACKGROUND:

The documentation related to the matter for [Provider/Supplier Name] has been reviewed and the decision has been made in accordance with the applicable Medicare rules, policies, and program instructions.

(Summarize the facts underlying the case which led up to the submission of the reconsideration request.)

RECONSIDERATION ANALYSIS:

(The hearing officer needs to check to determine if a CAP was also submitted and approved for this provider or supplier. If so, the reconsideration decision should only address the remaining authorities and use the following sentence, “[MAC Name] has denied or approved the CAP submitted on [Month] [DD], [YYYY] in a decision dated [Month] [DD], [YYYY]. Therefore, this decision will only address the remaining revocation reason(s) 42 C.F.R. § 424.535(a)(revocation reason 1-22).)

(If the CAP resolves the revocation in its entirety, the applicable moot model letter should be issued in response to the reconsideration request instead of this decision template.)

(A reconsideration request reviews whether or not an error was made at the time the initial determination was implemented. This section should summarize the statements made by the provider or supplier in its reconsideration request. Then conduct analysis of the arguments based on the applicable regulations and sub-regulations (MPIM). This section shall not reference a reconsideration decision without explaining how and why you came to that decision.)

DECISION:

(A short conclusory restatement.)

(On [Month] [DD], [YYYY], Jane Doe’s medical license was suspended by the Wisconsin Medical Board. Jane Doe has not submitted evidence to demonstrate that the suspension of her medical license was rescinded. In addition, [MAC Name] has

confirmed that Jane Doe's medical license remains suspended. As a result, [MAC Name] upholds the revocation of Jane Doe's Medicare enrollment application under 42 C.F.R. § 424.535(a)(1).)

This decision is an **UNFAVORABLE DECISION**. [MAC name] concludes that there was no error made in the implementation of a revocation. As a result, the revocation of your Medicare billing privileges is upheld.

FURTHER APPEAL RIGHTS - ADMINISTRATIVE LAW JUDGE (ALJ):

If you are satisfied with this decision, you do not need to take further action. If you believe that this determination is not correct, you may request ALJ review for the reconsideration portion of this decision letter. To request ALJ review, you must file your appeal with the Civil Remedies Division of the Departmental Appeals Board within 60 calendar days after the date of receipt of this decision.

How to file a hearing request

You can file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at <https://dab.efile.hhs.gov/>.

To file a new appeal using DAB E-File, you first need to register a new account by:

1. Clicking Register on the DAB E-File home page;
2. Entering the information requested on the "Register New Account" form; and
3. Clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.

The e-mail address and password provided during registration must be entered on the login screen at https://dab.efile.hhs.gov/user_sessions/new to access DAB E-File. A registered user's access to DAB E-File is restricted to the appeals for which he or she is a party or authorized representative.

Once registered, you may file your appeal by logging in and:

- Clicking the File New Appeal link on the Manage Existing Appeals screen, and then clicking Civil Remedies Division on the File New Appeal screen; and
- Entering and uploading the requested information and documents on the "File New Appeal – Civil Remedies Division" form.

All documents must be submitted in PDF form.

What you must include in a hearing request for ALJ review

At minimum, the Civil Remedies Division (CRD) requires a party to file the following:

- A signed request for hearing that:
 - Identifies the specific issues and the findings of fact and conclusions of law with which the party disagrees; and
 - Specifies the basis for contending that the findings and conclusions are incorrect;
- The underlying notice letter from CMS that sets forth the action taken and the party's appeal rights.

In addition, the following identifying information is required with all ALJ hearing requests:

- Your legal business name
- Your Medicare PTAN (if applicable)
- Tax Identification Number (TIN) or Employer Identification Number (EIN)
- A copy of the Hearing Officer or the CMS Regional Office (RO) decision

The procedures for ALJ review can be found at Title 42 of the Code of Federal Regulations, sections 498.40 – 498.79.

Guidelines for Using DAB E-file

- Any document, including a request for hearing, will be deemed to have been filed on a given day if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day.
- A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the ALJ, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service.
- Parties are responsible for ensuring that DAB E-file email notifications do not go to their spam folders and that any spam filtering software they may have does not restrict their ability to receive emails from the system.
- More detailed instructions on DAB E-File for CRD cases can be

found by clicking the CRD E- File Procedures link on the File New Appeal Screen for CRD appeals.

If you are unable to use DAB E-file

Parties are required to use DAB E-file unless they receive a waiver. If you cannot file your appeal electronically, you may mail your hearing request, along with a request for waiver of the electronic filing requirement and an explanation of why you cannot use DAB E-file, to: Department of Health and Human Services, Departmental Appeals Board, Civil Remedies Division, Mail Stop 6132, Attn: CMS Enrollment Appeal, 330 Independence Avenue, S.W., Cohen Building, Room G-644, Washington, D.C. 20201.

Appeal rights can be found 42 C.F.R. part 498. The regulation explains the appeal rights following the determination by the CMS as to whether such entities meet the requirements for enrollment in the Medicare program.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address]
[Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

Q. Reconsideration Further Information Required for Development Model Letter

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

To: [Email address provided by the person who submitted the Reconsideration.]

Subject: Medicare Provider Enrollment Reconsideration re: [Provider/Supplier Name]

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Reconsideration] (If submitted on behalf of an organization or group) [Address] (Address from which the Reconsideration was sent)
[City], [State] [Zip Code]

Re: Reconsideration Decision

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)

NPI: [XXXXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXX] (Internal Tracking)

Dear [Name of the person(s) who submitted the Reconsideration]:

On [Month] [DD], [YYYY], [MAC Name] issued a reconsideration decision. As stated in the [Month] [DD], [YYYY] reconsideration decision letter, the approval of [Provider/Supplier Name]'s Medicare enrollment is contingent upon the submission of [list required documentation]. Please send the required documentation within 30 calendar days to:

[MAC Reconsideration Receipt Address] [MAC Reconsideration Receipt Email Address] [MAC Reconsideration Receipt Fax Number]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Signature of Hearing Officer] (May be electronic) [Name of Hearing Officer]

[Position of Hearing Officer]

[MAC Name]

10.7.12 – Deactivation Model Letter

(Rev. 10611; Issued: 03-19-21; Effective:11-19-20; Implementation: 11-19-20)

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [DD], [YYYY]

[Provider/Supplier Name] (as it appears in PECOS)

[Address]

[City], [State] [Zip Code]

Re: Deactivation of Medicare billing privileges

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)

NPI: [XXXXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXX] (Internal Tracking)

Dear [Provider/Supplier Name]:

Your Medicare billing privileges are being deactivated effective [Month] [DD], [YYYY] pursuant to:

DEACTIVATION REASON:

- 42 C.F.R. § 424.540(a)[1-2]

[Specific reason for the deactivation of the provider/supplier's Medicare billing privileges.]

(If the deactivation is under 424.540(a)(1), an example narrative may include:

[MAC Name] has reviewed your Medicare billing data and found that you have not submitted any claims since January 1, 2017, which is more than twelve calendar months from the date of this letter.)

(If the deactivation is under 424.540(a)(2), an example narrative may include:

[MAC Name] has been informed that John Smith is deceased as of January 1, 2017. Your Medicare enrollment application, signed and certified on November 1, 2016, identifies John Smith as a 5% or greater owner. [MAC Name] has not received a Medicare enrollment application reporting this change in ownership.)

REBUTTAL RIGHTS:

If you believe that this determination is not correct, you may rebut the deactivation as indicated in 42 C.F.R. § 424.545(b). The rebuttal must be received by this office in writing within 20 calendar days of the date of this letter. The rebuttal must state the issues or findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the rebuttal that you believe may have a bearing on the decision. You must submit all information that you would like to be considered in conjunction with the rebuttal. This includes any application(s) to update your enrollment, if necessary. You may only submit one rebuttal in response to this deactivation of your Medicare enrollment.

The rebuttal must be signed and dated by the individual provider/supplier, the authorized or delegated official, or a legal representative.

If the provider/supplier wishes to appoint a legal representative that is not an attorney to sign the rebuttal, the provider/supplier must include with the rebuttal a written notice authorizing the legal representative to act on the provider/supplier's behalf. The notice should be signed by the provider/supplier.

If the provider/supplier has an attorney sign the rebuttal, the rebuttal must include a statement from the attorney that he/she has the authority to represent the provider/supplier.

If you wish to receive communication regarding your rebuttal via email, please include a valid email address in your rebuttal submission.

The rebuttal should be sent to the following:

[MAC Rebuttal Receipt Address]

[MAC Rebuttal Receipt Email Address]

[MAC Rebuttal Receipt Fax Number]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name] [Title] [Company]

10.7.13 – Rebuttal Model Letters

(Rev. 10611; Issued: 03-19-21; Effective:11-19-20; Implementation: 11-19-20)

Instruction

For the following model letters, all text within parentheses is intended as instruction/explanation and should be deleted before the letter is finalized and sent to the provider or supplier. All text within brackets requires the contractor to fill in the appropriate text. All letters shall be saved in PDF format.

A. Rebuttal Signature Development Model Letter

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

To: [Email address provided by the person who submitted the rebuttal.]

Subject: Medicare Provider Enrollment Rebuttal re: [Provider/Supplier Name]

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of Rebuttal] (If submitted on behalf of an organization or group)

[Address] (Address from which the rebuttal was sent)

[City], [State] [Zip Code]

Re: Rebuttal Determination

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)

NPI: [XXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXX] (Internal Tracking)

Dear [Name of the person(s) who submitted the rebuttal]:

We are in receipt of your rebuttal submission, received on [Month] [DD], [YYYY].

(If the submission is not properly signed, use the following.) Your submission is not appropriately signed, as required in the Medicare Program Integrity Manual, Ch. 10, Section 10.4(M). [MAC Name] is requesting that you submit a rebuttal properly signed by the individual provider, supplier, the authorized or delegated official, or a legal representative. Your properly signed submission must be received within 15 calendar days of the date of this notice. If you do not timely respond to this request, your rebuttal submission may be dismissed.

(If the submission is missing a statement by the attorney, use the following.) Your submission is missing an attorney statement that he or she has the authority to represent the provider or supplier. [MAC Name] is requesting that you submit a rebuttal that includes an attorney statement that he or she has the authority to represent the provider or supplier within 15 calendar days of the date of this notice. If you do not timely respond to this request, your rebuttal submission may be dismissed.

(If the submission is missing a signed written notice from the provider/supplier authorizing the legal representative to act on his/her/its behalf, use the following.) Your submission is missing a written notice of the appointment of a representative signed by the provider or supplier. [MAC Name] is requesting that you submit written notice of the appointment of a representative that is signed by the provider or supplier within 15 calendar days of the date of this notice. If you do not timely respond to this request, your rebuttal submission may be dismissed.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]

[Position of Hearing Officer]

[MAC Name]

B. Rebuttal Further Information Required Development Model Letter

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

To: [Email address provided by the person who submitted the rebuttal.]

Subject: Medicare Provider Enrollment Rebuttal re: [Provider/Supplier Name]

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of Rebuttal] (If submitted on behalf of an organization or group)

[Address] (Address from which the rebuttal was sent)

[City], [State] [Zip Code]

Re: Rebuttal Determination

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)

NPI: [XXXXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXX] (Internal Tracking)

Dear [Name of the person(s) who submitted the rebuttal]:

On [Month] [DD], [YYYY], [MAC Name] issued a favorable rebuttal determination, reversing the deactivation of [Provider/Supplier Name]'s Medicare billing privileges. As stated in the [Month] [DD], [YYYY] determination letter, the reactivation of [Provider/Supplier Name]'s Medicare enrollment is contingent upon the submission of [list required documentation]. Please send the required documentation to:

[MAC Rebuttal Receipt Address]

[MAC Rebuttal Receipt Email Address]

[MAC Rebuttal Receipt Fax Number]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]

[Position of Hearing Officer]

[MAC Name]

C. Rebuttal Moot Model Letter

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

To: [Email address provided by the person who submitted the rebuttal.]

Subject: Medicare Provider Enrollment Rebuttal re: [Provider/Supplier Name]

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of Rebuttal] (If submitted on behalf of an organization or group)

[Address] (Address from which the rebuttal was sent)

[City], [State] [Zip Code]

Re: Rebuttal Determination

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)

NPI: [XXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXX] (Internal Tracking)

Dear [Name of the person(s) who submitted the rebuttal]:

This letter is in response to the rebuttal submission, received on [Month] [DD], [YYYY]. On [Month] [DD], [YYYY], [MAC Name] approved an application to reactivate [Name of Provider/Supplier]'s Medicare billing privileges without a gap. Therefore, the issue set forth in the rebuttal submission is no longer actionable. As a result, this issue is moot and a determination will not be made in regards to the rebuttal submission.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]

[Position of Hearing Officer]

[MAC Name]

D. Rebuttal Withdrawn Model Letter

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

To: [Email address provided by the person who submitted the rebuttal.]

Subject: Medicare Provider Enrollment Rebuttal re: [Provider/Supplier Name]

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of Rebuttal] (If submitted on behalf of an organization or group)
[Address] (Address from which the rebuttal was sent)
[City], [State] [Zip Code]

Re: Rebuttal Determination
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (Internal Tracking)

Dear [Name of the person(s) who submitted the rebuttal]:

We are in receipt of your written withdrawal request in regards to your rebuttal received on [Month] [DD], [YYYY]. [MAC Name] has not yet issued a rebuttal determination. Therefore, [MAC Name] considers your rebuttal to be withdrawn. As a result, a determination will not be issued in response to your rebuttal and your Medicare billing privileges will remain deactivated.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

E. Rebuttal Receipt Acknowledgement Model Letter

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

To: [Email address provided by the person who submitted the rebuttal.]

Subject: Medicare Provider Enrollment Rebuttal re: [Provider/Supplier Name]

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal] (If submitted on behalf of an organization or group)
[Address] (Address from which the rebuttal was sent)
[City], [State] [Zip Code]

Re: Rebuttal Determination

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (Internal Tracking)

Dear [Name of the person(s) who submitted the rebuttal]:

We are in receipt of your rebuttal on behalf of [Provider/Supplier Name]. Please be advised that [MAC Name] has made an interim determination to maintain the deactivation of your Medicare billing privileges. However, [MAC Name] will further review the information and documentation submitted in your rebuttal and will render a final determination regarding the deactivation of your Medicare billing privileges within 30 days of the date of receipt.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

F. Final Rebuttal Decision Email Template

To: [Email address provided by the person who submitted the rebuttal.]

Subject: Medicare Provider Enrollment Rebuttal re: [Provider/Supplier Name]

(To be sent by hard-copy mail and email if email address is provided. Be sure to attach a copy of the final rebuttal determination in PDF format, if sent via email.)

Dear [Name of the person(s) who submitted the rebuttal]:

Please see the attached determination regarding your rebuttal.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

G. Rebuttal Dismissal Model Letters

1. Untimely Rebuttal Dismissal Model Letter

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

To: [Email address provided by the person who submitted the rebuttal.]

Subject: Medicare Provider Enrollment Rebuttal re: [Provider/Supplier Name]

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of Rebuttal] (If submitted on behalf of an organization or group)

[Address] (Address from which the rebuttal was sent)

[City], [State] [Zip Code]

Re: Rebuttal Determination

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)

NPI: [XXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXX] (Internal Tracking)

Dear [Name of the person(s) who submitted the rebuttal]:

This letter is in response to the rebuttal received by [MAC Name], based on the letter deactivating your Medicare billing privileges dated [Month] [DD], [YYYY].

[MAC Name] is unable to accept your rebuttal as it was not timely submitted. The deactivation letter was dated [Month] [DD], [YYYY]. A rebuttal must be received within 20 calendar days of the date of the [Month] [DD], [YYYY] deactivation letter. Your rebuttal was not received until [Month] [DD], [YYYY], which is beyond the applicable submission time frame. [Provider/Supplier/Legal Representative/Representative] failed to show good cause for its late request. Therefore, [MAC Name] is unable to render a determination in this matter and your Medicare billing privileges will remain deactivated.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]

[Position of Hearing Officer]
[MAC Name]

2. Improper Signature Rebuttal Dismissal Model Letter

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

To: [Email address provided by the person who submitted the rebuttal.]

Subject: Medicare Provider Enrollment Rebuttal re: [Provider/Supplier Name]

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of Rebuttal] (If submitted on behalf of an organization or group)

[Address](Address from which the rebuttal was sent)

[City], [State] [Zip Code]

Re: Rebuttal Determination

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)

NPI: [XXXXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXX] (Internal Tracking)

Dear [Name of the person(s) who submitted the rebuttal]:

This letter is in response to the rebuttal received by [MAC Name], based on the letter deactivating your Medicare billing privileges dated [Month] [DD], [YYYY].

[MAC Name] is unable to accept your rebuttal as it was not signed by an authorized or delegated official currently on file in your Medicare enrollment, the individual provider or supplier, a legal representative, or did not contain the required statement of representation from an attorney or signed written notice appointing a non-attorney legal representative. The signature requirement is stated in the [Month] [DD], [YYYY] deactivation letter. Please be advised that a properly signed rebuttal must be received within 20 calendar days of the date of the deactivation letter.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]

[Position of Hearing Officer]

[MAC Name]

3. No Rebuttal Rights Rebuttal Dismissal Model Letter

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

To: [Email address provided by the person who submitted the rebuttal.]

Subject: Medicare Provider Enrollment Rebuttal re: [Provider/Supplier Name]

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of Rebuttal] (If submitted on behalf of an organization or group)

[Address](Address from which the rebuttal was sent)

[City], [State] [Zip Code]

Re: Rebuttal Determination

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)

NPI: [XXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXX] (Internal Tracking)

Dear [Name of the person(s) who submitted the rebuttal]:

This letter is in response to the rebuttal received by [MAC Name].

[MAC Name] is unable to accept your rebuttal submission because the action taken in regards to your Medicare billing privileges does not afford the opportunity for a rebuttal. Under 42 C.F.R. § 424.545(b), only a provider or supplier whose Medicare billing privileges are deactivated may file a rebuttal in accordance with 42 C.F.R. § 405.374.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]

[Position of Hearing Officer]

[MAC Name]

4. More than One Submission Rebuttal Dismissal Model Letter

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

To: [Email address provided by the person who submitted the rebuttal.]

Subject: Medicare Provider Enrollment Rebuttal re: [Provider/Supplier Name]

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of Rebuttal] (If submitted on behalf of an organization or group)

[Address](Address from which the rebuttal was sent)

[City], [State] [Zip Code]

Re: Rebuttal Determination

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)

NPI: [XXXXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXX] (Internal Tracking)

Dear [Name of the person(s) who submitted the rebuttal]:

This letter is in response to the rebuttal received by [MAC Name], based on the deactivation letter dated [Month] [DD], [YYYY].

[MAC Name] previously received a rebuttal for [Provider/Supplier Name] on [Month] [DD], [YYYY]. Per Chapter 10 of the Medicare Program Integrity Manual, only one rebuttal request may be submitted per deactivation. Therefore, [MAC Name] is unable to accept your additional rebuttal[s] received on [Month] [DD], [YYYY].

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]

[Position of Hearing Officer]

[MAC Name]

H. Rebuttal Not Actionable Model Letter (Moot)

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

To: [Email address provided by the person who submitted the rebuttal.]

Subject: Medicare Provider Enrollment Rebuttal re: [Provider/Supplier Name]

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of Rebuttal] (If submitted on behalf of an organization or group)

[Address](Address from which the rebuttal was sent)

[City], [State] [Zip Code]

Re: Rebuttal Determination

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)

NPI: [XXXXXXXXXX]

PTAN: [XXXXX]

Reference Number: [XXXX] (Internal Tracking)

Dear [Name of the person(s) who submitted the rebuttal]:

This letter is in response to the rebuttal received by [MAC Name], concerning the deactivation of [Provider/Supplier Name]'s Medicare billing privileges, effective [Month] [DD], [YYYY].

On [Month] [DD], [YYYY], [MAC Name] reopened the deactivation for [Provider/Supplier Name] and issued a revised initial determination. This revised initial determination rendered the issue set forth in your rebuttal no longer actionable. Accordingly, the issue addressed in your rebuttal is now moot, and we are unable to render a determination on the matter.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]

[Position of Hearing Officer]

[MAC Name]

I. Favorable Rebuttal Model Letter

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

To: [Email address provided by the person who submitted the rebuttal.]

Subject: Medicare Provider Enrollment Rebuttal re: [Provider/Supplier Name]

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of Rebuttal] (If submitted on behalf of an organization or group)

[Address](Address from which the Rebuttal was sent)

[City], [State] [Zip Code]

Re: Rebuttal Determination

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)

NPI: [XXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXX] (Internal Tracking)

Dear [Name of the Person(s) who submitted the rebuttal]:

This letter is in response to the rebuttal received by [MAC Name] based on the deactivation of [Provider/Supplier Name]'s Medicare billing privileges. The deactivation letter was dated [Month] [DD], [YYYY]; therefore, this rebuttal is considered timely. The following determination is based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

DEACTIVATION REASON:

42 C.F.R. § 424.540(a)(1-3)

OTHER APPLICABLE AUTHORITIES:

42 C.F.R. §

Medicare Program Integrity Manual (MPIM) chapter 10.XX (If applicable).

EXHIBITS:

- Exhibit 1: (**Example:** Rebuttal letter to CMS, signed by John Smith, Administrator for Home Healthcare Services, LLC, dated January 1, 2018);
- Exhibit 2: (**Example:** Letter from MAC to Home Healthcare Services, LLC, dated December 1, 2017, deactivating Home Healthcare Services, LLC's Medicare billing privileges pursuant to 42 C.F.R. § 424.540(a)(3)).

(In this section list each document submitted by the provider or supplier. Each exhibit should include the date, as well as a brief description of the document. You shall also include other documentation not submitted by the provider that the hearing officer

reviewed in making the determination, e.g., enrollment applications, development letters, etc.)

BACKGROUND:

The documentation related to the matter for [Provider/Supplier Name] has been reviewed and the determination has been made in accordance with the applicable Medicare rules, policies and program instructions.

(Summarize the facts underlying the case which led up to the submission of the rebuttal.)

REBUTTAL ANALYSIS:

(A rebuttal reviews whether or not an error was made in the implementation of the deactivation of the provider's or supplier's Medicare billing privileges. This section should summarize the statements made by the provider or supplier in its rebuttal. Then conduct analysis of the arguments based on the applicable regulations and sub-regulations, MPIM. It is insufficient to state a rebuttal determination without explaining how and why the determination was made.)

DECISION:

(A short conclusory restatement.)

(Example: On [Month] [DD], [YYYY], [MAC Name] received a revalidation application for Home Healthcare Services, LLC. On [Month] [DD], [YYYY], [MAC Name] rejected Home Healthcare Services, LLC's revalidation application prior to 90 calendar days from the date of the revalidation request letter. As a result, [MAC Name] finds that the deactivation of Home Healthcare Services, LLC's Medicare billing privileges is not justified based on the information available.

This decision is a **FAVORABLE DETERMINATION**. To effectuate this determination, [MAC name] will reinstate [Provider/Supplier Name]'s Medicare billing privileges.

(If additional information is needed from the provider or supplier in order to reactivate the enrollment, the MAC shall state what information is needed from the provider or supplier in this rebuttal determination. MACs shall state that the requested information/documentation must be received within 30 calendar days of the date of this determination letter)

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

J. Unfavorable Rebuttal Model Letter

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

To: [Email address provided by the person who submitted the rebuttal.]

Subject: Medicare Provider Enrollment Rebuttal re: [Provider/Supplier Name]

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal] (If submitted on behalf of an organization or group)
[Address](Address from which the Rebuttal was sent)
[City], [State] [Zip Code]

Re: Rebuttal Determination

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)

NPI: [XXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXX] (Internal Tracking)

Dear [Person(s) who submitted the rebuttal]:

This letter is in response to the rebuttal received by [MAC Name] based on the deactivation of [Provider/Supplier Name]'s Medicare billing privileges. The deactivation letter was dated [Month] [DD], [YYYY]; therefore, this rebuttal is considered timely. The following determination is based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

DEACTIVATION REASON:

42 C.F.R. § 424.540(a)(1-3)

OTHER APPLICABLE AUTHORITIES:

42 C.F.R. §

Medicare Program Integrity Manual chapter 10.XX (If applicable)

EXHIBITS:

- Exhibit 1: (**Example:** Rebuttal letter to CMS, signed by John Smith, Administrator for Home Healthcare Services, LLC, dated January 1, 2018);
- Exhibit 2: (**Example:** Letter from MAC to Home Healthcare Services, LLC, dated December 1, 2017, deactivating Home Healthcare Services, LLC's Medicare billing privileges pursuant to 42 C.F.R. § 424.540(a)(3)).

(In this section list each document submitted by the provider or supplier. Each exhibit should include the date, as well as a brief description of the document. You shall also include other documentation not submitted by the provider that the hearing officer reviewed in making the determination, e.g., enrollment applications, development letters, etc.)

BACKGROUND:

The documentation related to the matter for [Provider/Supplier Name] has been reviewed and the determination has been made in accordance with the applicable Medicare rules, policies, and program instructions.

[Summarize the facts underlying the case which led up to the submission of the rebuttal.]

REBUTTAL ANALYSIS:

(A rebuttal reviews whether or not an error was made in the implementation of the deactivation of the provider's or supplier's Medicare billing privileges. This section should summarize the statements made by the provider or supplier in its rebuttal. Then conduct analysis of the arguments based on the applicable regulations and sub-regulations, MPIM. It is insufficient to state a rebuttal determination without explaining how and why the determination was made.)

DECISION:

(A short conclusory restatement.)

(**Example:** On [Month] [DD], [YYYY], [MAC Name] received a revalidation application for Home Healthcare Services, LLC. On [Month] [DD], [YYYY], [MAC Name] sent a development request to continue processing Home Healthcare Services, LLC's revalidation application. Home Healthcare Services, LLC did not timely respond to [MAC Name]'s development request. As a result, [MAC Name] properly rejected Home Healthcare Services, LLC's revalidation application. Therefore, [MAC Name] finds that the deactivation of Home Healthcare Services, LLC's Medicare enrollment under 42 C.F.R. § 424.540(a)(1-3) is justified.)

This decision is an **UNFAVORABLE DETERMINATION**. [MAC name] concludes that there was no error made in the deactivation of your Medicare billing privileges. As a result, your Medicare billing privileges will remain deactivated.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]

[Position of Hearing Officer]

[MAC Name]

10.7.14 – Model Opt-out Letters

(Rev. 10524; Issued: 12-17-20; Effective: 11-13-20; Implementation: 11-13-20)

The MACs shall use the model letters in this section to respond to eligible practitioners' opt-out affidavits, request additional documentation, approve opt out affidavits and acknowledge the cancelation or early termination of an opt-out. The MACs shall not use these model letters to respond to Medicare enrollment applications or other correspondence. The MACs may issue the Model Opt-out Development Letter via fax, e-mail or mail to the eligible practitioner.

A. Opt-out Affidavit Development Letter

MACs shall use the following letter to request missing information from an eligible practitioner that wishes to opt-out of Medicare. This letter should be sent only one time and include a request for all missing information. The MAC may select the response type, either via mail, fax or email.

[month] [day], [year]

[Eligible Practitioner Name]

[Address]

[City] ST [Zip]

Reference: Case/Control Number

Dear [Eligible Practitioner]:

[Insert MAC] requires the following information to complete the processing of your Medicare opt-out affidavit:

[Specify information needed]

Submit the requested information within 30 calendar days of the postmark date of this letter [to the address listed below, via fax to (###-###-####), or via email to (enter PE analyst's email address here)]. We may reject your opt-out affidavit if you do not furnish the requested information within this timeframe.

[Name of MAC]

[Address]

[City], [ST] [Zip]

Attach a copy of this letter with your revised opt-out affidavit.

For questions concerning this letter, contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM.]

Sincerely,

[Name]

[Title]

[Company]

B. Opt-out Rejection Letter

In the event that an eligible practitioner does not respond timely or does not respond with needed information to complete an opt-out affidavit, the MACs shall issue this rejection letter.

[month] [day], [year]

[Eligible Practitioner Name]

[Address]

[City] ST [Zip]

Reference: Case/Control Number

Dear Eligible Practitioner Name:

[Insert MAC] is rejecting your Medicare opt-out affidavit, received on [insert date], for the following reason(s):

[List all reasons for rejection:]

To resubmit your opt-out affidavit include all information needed to process your opt-out request. Additional information on submitting a complete opt-out affidavit can be found at: [enter MAC website address].

Return the completed opt-out affidavit to:

[Name of MAC]

[Address]

[City], [ST] [Zip]

For questions concerning this letter, contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name]

[Title]

[Company]

C. Opt-out Return Letters

Opt-out affidavits should only be returned for the following reasons:

1. The eligible practitioner requesting to opt-out of Medicare is not appropriately licensed by the state,
2. The practitioner is a specialty that is ineligible to opt-out (e.g., Chiropractic Medicine, Physical Therapy, Occupational Therapy, etc.),
3. The opt-out affidavit is filed with an incorrect MAC,
4. The eligible practitioner decides not to opt out of Medicare while their opt-out affidavit is still in process, but not yet approved by the MAC,
5. The eligible practitioner submits a cancellation request too late (within 30 days of the auto-renewal date or after the auto-renewal date), this return letter provides appeal rights, or
6. The eligible practitioner submits a cancellation request more than 90 days prior to the auto-renewal date.

MACs shall issue the specific letter for the return reason.

1. Opt-out Return Letter – Unlicensed Eligible Practitioner

[month] [day], [year]

[Eligible Practitioner Name]

[Address]

[City] ST [Zip]

Reference: Case/Control Number

Dear [Eligible Practitioner Name]:

[Insert MAC] is returning your Medicare opt-out affidavit, submitted on [insert date], as you are not licensed by the state for the specialty type you indicated on your opt-out affidavit.

For questions concerning this letter, contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name]

[Title]

[Company]

2. Opt-out Return Letter – Ineligible Practitioner

[month] [day], [year]

[Eligible Practitioner Name]

[Address]

[City] ST [Zip]

Reference: Case/Control Number

Dear [Eligible Practitioner Name]:

[Insert MAC] is returning your Medicare opt-out affidavit, submitted on [insert date], because you indicated a specialty that is ineligible to opt-out (e.g., Chiropractic Medicine, Physical Therapy, Occupational Therapy, etc.) of Medicare.

For questions concerning this letter, contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name]
[Title]
[Company]

3.Opt-out Return Letter – Submitted to Incorrect MAC

[month] [day], [year]

[Eligible Practitioner Name]

[Address]

[City] ST [Zip]

Reference: Case/Control Number

Dear [Eligible Practitioner Name]:

[Insert MAC] is returning your Medicare opt-out affidavit, submitted on [insert date], because your opt-out affidavit was filed with an incorrect Medicare Administrative Contractor for the state that you are located in. Your affidavit should be resubmitted to the appropriate contractor for processing.

For questions concerning this letter, contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name]
[Title]
[Company]

4. Opt-out Return Letter – Withdraw of Affidavit During Processing

[month] [day], [year]

[Eligible Practitioner Name]

[Address]

[City] ST [Zip]

Reference: Case/Control Number

Dear [Eligible Practitioner Name]:

[Insert MAC] is returning your Medicare opt-out affidavit, submitted on [insert date], because you have decided to withdraw your opt-out affidavit while it is still in process.

For questions concerning this letter, contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name]

[Title]

[Company]

5. Opt-out Return Letter – Late Cancellation Request

[month] [day], [year]

[Eligible Practitioner Name]

[Address]

[City] ST [Zip]

Reference: Case/Control Number

Dear [Eligible Practitioner Name]:

[Insert MAC] is returning your written request to cancel the automatic renewal your Medicare opt-out status, submitted on [insert date], as it was [not submitted at least 30 days prior to the end of your current opt-out period]/[received after the opt-out period automatically renews.]

APPEAL RIGHTS

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination.

Reconsideration requests must:

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the eligible practitioner that has been reported on your opt-out affidavit or an authorized representative.
 - If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the eligible practitioner is sufficient to accept this individual as the representative.
 - If the authorized representative is not an attorney, the eligible practitioner, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.

Eligible practitioners may:

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.
- Include an email address if you want to receive correspondence regarding your appeal via email.

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

[Centers for Medicare & Medicaid Services]
[Provider Enrollment & Oversight Group]
[ATTN: Division of Compliance & Appeals]

[7500 Security Blvd.]
[Mailstop: AR-18-50]
[Baltimore, MD 21244-1850]

Or emailed to:

[ProviderEnrollmentAppeals@cms.hhs.gov]

For questions concerning this letter, contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,
[Name]
[Title]
[Company]

6. Opt-out Return Letter – Cancellation Request Submitted Too Early

[month] [day], [year]
[Eligible Practitioner Name]

[Address]

[City] ST [Zip]

Reference: Case/Control Number

Dear [Eligible Practitioner Name]:

[Insert MAC] is returning your written request to cancel the automatic renewal your Medicare opt-out status, submitted on [insert date], as it was submitted at more than 90 days prior to the end of your current opt-out period.

Please submit your cancellation request no later than 30 days prior to the end of your current opt-out period to avoid auto-renewal of your opt-out status. Your auto-renewal date is: [insert date].

For questions concerning this letter, contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,
[Name]
[Title]
[Company]

D. Opt-out Affidavit Approval Letters

The MACs shall issue an Opt-out Affidavit Approval model letter when approving an opt-out affidavit and PECOS has been updated with the affidavit information. The approval letter shall be issued for the following reasons:

1. Approved Opt-Out, Eligible Practitioner May Order & Refer
2. Approved Opt-Out, Eligible Practitioner May Not Order & Refer (OIG Exclusion)
3. Approved Opt-Out, Eligible Practitioner May Not Order & Refer (Ineligible Specialty)
4. Approved Opt-Out, Eligible Practitioner May Not Order & Refer (Did Not Elect to Order & Refer)
5. Approved Opt-Out, Eligible Practitioner May Not Order & Refer (Eligible Practitioner Does Not Have an NPI)
6. Approved Opt-Out, Eligible Practitioner May Not Order & Refer (Eligible Practitioner has Revoked Billing Privileges)
7. Approved Opt-Out Change of Information

The Opt-out approval letter shall include:

- The eligible practitioner's personal information:
 - Name,
 - Address,
 - NPI,
 - Specialty, and
 - Eligibility to order and refer.
- The eligible practitioner's opt-out effective date.
- The date that the eligible practitioner can submit a request to cancel their opt-out affidavit (at least 30 days prior to the end-date of their current opt-out period).
- The date the eligible practitioner can terminate his/her opt-out early (if they are eligible to so, no later than 90 days after the effective date) of the eligible practitioner's initial 2-year opt-out period.
- Should the eligible practitioner opt-out a subsequent time after cancelling, contractors shall remove the paragraph noting "Since you are opting out for the very first time..." since this statement no longer applies.

1. Opt-out Affidavit Approval Letter – Eligible Practitioner Approved to Order & Refer

[month] [day], [year]

[Eligible Practitioner Name]

[Address]

[City] ST [Zip]

Reference: Case/Control Number

Dear [Eligible Practitioner Name]:

[Insert MAC] approved your Medicare opt-out affidavit.

Opt-out Affidavit Information:

| | |
|-------------------------------------|-------------------------------------|
| Eligible Practitioner Name: | [Name] |
| Address on File: | [Address, City, State, Zip] |
| National Provider Identifier (NPI): | [NPI] |
| Specialty: | [Specialty] |
| Ordering and Referring: | You are eligible to Order and Refer |
| Effective Date: | [Effective date] |

Your opt-out will automatically renew every 2 years.

Since you are opting out for the very first time, you have a one-time, 90-day period to change your mind about opting out. If you decide to terminate during this 90-day period, you must submit your request, in writing, no later than [Month DD, YYYY]. After this 90-day period ends, you can only cancel the opt-out at the end of a 2 year opt-out period. If you were unable to submit a termination request, you may appeal after the 90-day period ends. Please follow the Appeal Rights sections below.

To cancel opt-out, you must submit a cancellation request at least 30 days prior to the end of the opt-out period. For example, if you decide you want to cancel your opt-out at the end of this opt-out period, you must submit your cancellation request before [Month DD, YYYY].

APPEAL RIGHTS

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination.

Reconsideration requests must:

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.

- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the eligible practitioner that has been reported on your opt-out affidavit or an authorized representative.
 - If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the eligible practitioner is sufficient to accept this individual as the representative.
 - If the authorized representative is not an attorney, the eligible practitioner, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.

Eligible practitioners may:

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.
- Include an email address if you want to receive correspondence regarding your appeal via email.

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

[Centers for Medicare & Medicaid Services]
 [Provider Enrollment & Oversight Group]
 [ATTN: Division of Compliance & Appeals]
 [7500 Security Blvd.]
 [Mailstop: AR-18-50]
 [Baltimore, MD 21244-1850]

Or emailed to:

[ProviderEnrollmentAppeals@cms.hhs.gov]

For questions concerning this letter, contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name]

[Title]
[Company]

2. Opt-out Affidavit Approval Letter – Eligible Practitioner May Not Order & Refer (Excluded by the OIG)

[month] [day], [year]

[Eligible Practitioner Name]

[Address]

[City] ST [Zip]

Reference: Case/Control Number

Dear [Eligible Practitioner Name]:

[Insert MAC] approved your Medicare opt-out affidavit.

Opt-out Affidavit Information:

| | |
|-------------------------------------|--|
| Eligible Practitioner Name: | [Name] |
| Address on File: | [Address, City, State, Zip] |
| National Provider Identifier (NPI): | [NPI] |
| Specialty: | [Specialty] |
| Ordering and Referring: | You are not eligible to Order and Refer* |
| Effective Date: | [Effective date] |

* You have been excluded by the OIG (and even if you have or have not obtained a waiver according to 42 CFR §1001.1901(c)), you may opt-out of Medicare, but you are not permitted to order and refer items and services to Medicare beneficiaries

Your opt-out will automatically renew every 2 years.

Since you are opting out for the very first time, you have a one-time, 90 day period to change your mind about opting out. If you decide to terminate during this 90 day period, you must submit your request, in writing, no later than [Month DD, YYYY]. After this 90 day period ends, you can only cancel the opt-out at the end of a 2 year opt-out period. If you were unable to submit a termination request, you may appeal after the 90 day period ends. Please follow the Appeal Rights sections below.

To cancel opt-out, you must submit a cancellation request at least 30 days prior to the end of the opt-out period. For example, if you decide you want to cancel your opt-out at the end of this opt-out period, you must submit your cancellation request before [Month DD, YYYY].

APPEAL RIGHTS

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination.

Reconsideration requests must:

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the eligible practitioner that has been reported on your opt-out affidavit or an authorized representative.
 - If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the eligible practitioner is sufficient to accept this individual as the representative.
 - If the authorized representative is not an attorney, the eligible practitioner, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.

Eligible practitioners may:

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.
- Include an email address if you want to receive correspondence regarding your appeal via email.

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

[Centers for Medicare & Medicaid Services]
[Provider Enrollment & Oversight Group]
[ATTN: Division of Compliance & Appeals]

[7500 Security Blvd.]
[Mailstop: AR-18-50]
[Baltimore, MD 21244-1850]

Or emailed to:

[ProviderEnrollmentAppeals@cms.hhs.gov]

For questions concerning this letter, contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name]
[Title]
[Company]

3. Opt-out Affidavit Approval Letter – Eligible Practitioner May Not Order & Refer (Ineligible Specialty)

[month] [day], [year]

[Eligible Practitioner Name]

[Address]

[City] ST [Zip]

Reference: Case/Control Number

Dear [Eligible Practitioner Name]:

[Insert MAC] approved your Medicare opt-out affidavit.

Opt-out Affidavit Information:

| | |
|-------------------------------------|--|
| Eligible Practitioner Name: | [Name] |
| Address on File: | [Address, City, State, Zip] |
| National Provider Identifier (NPI): | [NPI] |
| Specialty: | [Specialty] |
| Ordering and Referring: | You are not eligible to Order and Refer* |
| Effective Date: | [Effective date] |

* You may opt-out of Medicare, but you are not permitted to order and refer items and services to Medicare beneficiaries, as your specialty is ineligible to order and refer.

Your opt-out will automatically renew every 2 years.

Since you are opting out for the very first time, you have a one-time, 90 day period to change your mind about opting out. If you decide to terminate during this 90 day period, you must submit your request, in writing, no later than [Month DD, YYYY]. After this 90 day period ends, you can only cancel the opt-out at the end of a 2 year opt-out period. If you were unable to submit a termination request, you may appeal after the 90 day period ends. Please follow the Appeal Rights sections below.

To cancel opt-out, you must submit a cancellation request at least 30 days prior to the end of the opt-out period. For example, if you decide you want to cancel your opt-out at the end of this opt-out period, you must submit your cancellation request before [Month DD, YYYY].

APPEAL RIGHTS

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination.

Reconsideration requests must:

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the eligible practitioner that has been reported on your opt-out affidavit or an authorized representative.
 - If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the eligible practitioner is sufficient to accept this individual as the representative.
 - If the authorized representative is not an attorney, the eligible practitioner, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.

Eligible practitioners may:

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only

opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.

- Include an email address if you want to receive correspondence regarding your appeal via email.

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

[Centers for Medicare & Medicaid Services]
[Provider Enrollment & Oversight Group]
[ATTN: Division of Compliance & Appeals]
[7500 Security Blvd.]
[Mailstop: AR-18-50]
[Baltimore, MD 21244-1850]

Or emailed to:

[ProviderEnrollmentAppeals@cms.hhs.gov]

For questions concerning this letter, contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name]
[Title]
[Company]

4. Opt-out Affidavit Approval Letter – Eligible Practitioner May Not Order & Refer (Did Not Elect to Order and Refer)

[month] [day], [year]

[Eligible Practitioner Name]

[Address]

[City] ST [Zip]

Reference: Case/Control Number

Dear [Eligible Practitioner Name]:

[Insert MAC] approved your Medicare opt-out affidavit.

Opt-out Affidavit Information:

| | |
|-------------------------------------|--|
| Eligible Practitioner Name: | [Name] |
| Address on File: | [Address, City, State, Zip] |
| National Provider Identifier (NPI): | [NPI] |
| Specialty: | [Specialty] |
| Ordering and Referring: | You are not eligible to Order and Refer* |
| Effective Date: | [Effective date] |

* You may opt-out of Medicare, but you are not permitted to order and refer items and services to Medicare beneficiaries as you did not elect to be and ordering and referring practitioner on your opt-out affidavit.

Your opt-out will automatically renew every 2 years.

Since you are opting out for the very first time, you have a one-time, 90 day period to change your mind about opting out. If you decide to terminate during this 90 day period, you must submit your request, in writing, no later than [Month DD, YYYY]. After this 90 day period ends, you can only cancel the opt-out at the end of a 2 year opt-out period. If you were unable to submit a termination request, you may appeal after the 90 day period ends. Please follow the Appeal Rights sections below.

To cancel opt-out, you must submit a cancellation request at least 30 days prior to the end of the opt-out period. For example, if you decide you want to cancel your opt-out at the end of this opt-out period, you must submit your cancellation request before [Month DD, YYYY].

APPEAL RIGHTS

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination.

Reconsideration requests must:

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the eligible practitioner that has been reported on your opt-out affidavit or an authorized representative.
 - If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the eligible practitioner is sufficient to accept this individual as the representative.

- If the authorized representative is not an attorney, the eligible practitioner, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.

Eligible practitioners may:

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.
- Include an email address if you want to receive correspondence regarding your appeal via email.

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

[Centers for Medicare & Medicaid Services]
[Provider Enrollment & Oversight Group]
[ATTN: Division of Compliance & Appeals]
[7500 Security Blvd.]
[Mailstop: AR-18-50]
[Baltimore, MD 21244-1850]

Or emailed to:

[ProviderEnrollmentAppeals@cms.hhs.gov]

For questions concerning this letter, contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name]

[Title]

[Company]

5. Opt-out Affidavit Approval Letter – Eligible Practitioner May Not Order & Refer (Eligible Practitioner Does Not Have an NPI)

[month] [day], [year]

[Eligible Practitioner Name]

[Address]

[City] ST [Zip]

Reference: Case/Control Number

Dear [Eligible Practitioner Name]:

[Insert MAC] approved your Medicare opt-out affidavit.

Opt-out Affidavit Information:

| | |
|-------------------------------------|--|
| Eligible Practitioner Name: | [Name] |
| Address on File: | [Address, City, State, Zip] |
| National Provider Identifier (NPI): | [Not Provided] |
| Specialty: | [Specialty] |
| Ordering and Referring: | You are not eligible to Order and Refer* |
| Effective Date: | [Effective date] |

* You may opt-out of Medicare, but you are not permitted to order and refer items and services to Medicare beneficiaries, as you have not obtained an NPI.

Your opt-out will automatically renew every 2 years.

Since you are opting out for the very first time, you have a one-time, 90 day period to change your mind about opting out. If you decide to terminate during this 90 day period, you must submit your request, in writing, no later than [Month DD, YYYY]. After this 90 day period ends, you can only cancel the opt-out at the end of a 2 year opt-out period. If you were unable to submit a termination request, you may appeal after the 90 day period ends. Please follow the Appeal Rights sections below.

To cancel opt-out, you must submit a cancellation request at least 30 days prior to the end of the opt-out period. For example, if you decide you want to cancel your opt-out at the end of this opt-out period, you must submit your cancellation request before [Month DD, YYYY].

APPEAL RIGHTS

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination.

Reconsideration requests must:

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the eligible practitioner that has been reported on your opt-out affidavit or an authorized representative.
 - If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the eligible practitioner is sufficient to accept this individual as the representative.
 - If the authorized representative is not an attorney, the eligible practitioner, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.

Eligible practitioners may:

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.
- Include an email address if you want to receive correspondence regarding your appeal via email.

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

[Centers for Medicare & Medicaid Services]
[Provider Enrollment & Oversight Group]
[ATTN: Division of Compliance & Appeals]
[7500 Security Blvd.]
[Mailstop: AR-18-50]
[Baltimore, MD 21244-1850]

Or emailed to:

[ProviderEnrollmentAppeals@cms.hhs.gov]

For questions concerning this letter, contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name]

[Title]

[Company]

6. Opt-out Affidavit Approval Letter – Eligible Practitioner May Not Order & Refer (Eligible Practitioner Has Revoked Billing Privileges)

[month] [day], [year]

[Eligible Practitioner Name]

[Address]

[City] ST [Zip]

Reference: Case/Control Number

Dear [Eligible Practitioner Name]:

[Insert MAC] approved your Medicare opt-out affidavit.

Opt-out Affidavit Information:

| | |
|-------------------------------------|--|
| Eligible Practitioner Name: | [Name] |
| Address on File: | [Address, City, State, Zip] |
| National Provider Identifier (NPI): | [NPI] |
| Specialty: | [Specialty] |
| Ordering and Referring: | You are not eligible to Order and Refer* |
| Effective Date: | [Effective date] |

* Your billing privileges have been revoked, you may opt-out of Medicare, but you are not permitted to order and refer items and services to Medicare beneficiaries

Your opt-out will automatically renew every 2 years.

Since you are opting out for the very first time, you have a one-time, 90 day period to change your mind about opting out. If you decide to terminate during this 90 day period, you must submit your request, in writing, no later than [Month DD, YYYY]. After this 90 day period ends, you can only cancel the opt-out at the end of a 2 year opt-out period. If you were unable to submit a termination request, you

may appeal after the 90 day period ends. Please follow the Appeal Rights sections below.

To cancel opt-out, you must submit a cancellation request at least 30 days prior to the end of the opt-out period. For example, if you decide you want to cancel your opt-out at the end of this opt-out period, you must submit your cancellation request before [Month DD, YYYY].

APPEAL RIGHTS

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination.

Reconsideration requests must:

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the eligible practitioner that has been reported on your opt-out affidavit or an authorized representative.
 - If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the eligible practitioner is sufficient to accept this individual as the representative.
 - If the authorized representative is not an attorney, the eligible practitioner, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.

Eligible practitioners may:

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.
- Include an email address if you want to receive correspondence regarding your appeal via email.

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

[Centers for Medicare & Medicaid Services]
[Provider Enrollment & Oversight Group]
[ATTN: Division of Compliance & Appeals]
[7500 Security Blvd.]
[Mailstop: AR-18-50]
[Baltimore, MD 21244-1850]

Or emailed to:

[ProviderEnrollmentAppeals@cms.hhs.gov]

For questions concerning this letter, contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].
Sincerely,

[Name]
[Title]
[Company]

7. Opt-out Affidavit Approval Letter – Approved Opt-Out Change of Information

[month] [day], [year]

[Eligible Practitioner Name]

[Address]

[City] ST [Zip]

Reference: Case/Control Number

Dear [Eligible Practitioner Name]:

[Insert MAC] has updated your Medicare opt-out affidavit.

Opt-out Affidavit Information:

| | |
|-------------------------------------|--|
| Eligible Practitioner Name: | [Name] |
| Address on File: | [Address, City, State, Zip] |
| National Provider Identifier (NPI): | [NPI] |
| Specialty: | [Specialty] |
| Ordering and Referring: | You [are/are not] eligible to Order and Refer[*] |
| Effective Date: | [Effective date] |
| Changed Information: | |

[* You may opt-out of Medicare, but you are not permitted to order and refer items and services to Medicare beneficiaries, as you have {enter reason for inability to order and refer}.]

As a reminder, to cancel opt-out, you must submit a cancellation request at least 30 days prior to the end of the opt-out period. For example, if you decide you want to cancel your opt-out at the end of this opt-out period, you must submit your cancellation request before [Month DD, YYYY].

For questions concerning this letter, contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].
Sincerely,

[Name]
[Title]
[Company]

E. Opt-out Renewal Alert Letter

The MACs shall issue the following letter, informing the eligible practitioner that the opt-out is due to be automatically renewed.

[month] [day], [year]

[Eligible Practitioner Name]

[Address]

[City] ST [Zip]

Reference: Case/Control Number

Dear Eligible Practitioner Name:

We are writing to inform you that your opt-out will be automatically renewed for a new 2 year opt-out period, on [Month, DD, YYYY].

To cancel your opt-out in the future, you will need to submit a cancellation request at least 30 days prior to the end of your opt-out period, which is [Month DD, YYYY].

If your intention is to cancel your opt-out, but fail to submit a cancellation notice to us, please see the Appeal Rights section of this letter below.

APPEAL RIGHTS

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination.

Reconsideration requests must:

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the eligible practitioner that has been reported on your opt-out affidavit or an authorized representative.
 - If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the eligible practitioner is sufficient to accept this individual as the representative.
 - If the authorized representative is not an attorney, the eligible practitioner, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.

Eligible practitioners may:

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.
- Include an email address if you want to receive correspondence regarding your appeal via email.

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

[Centers for Medicare & Medicaid Services]
[Provider Enrollment & Oversight Group]
[ATTN: Division of Compliance & Appeals]
[7500 Security Blvd.]
[Mailstop: AR-18-50]
[Baltimore, MD 21244-1850]

Or emailed to:

[ProviderEnrollmentAppeals@cms.hhs.gov]

For questions concerning this letter, contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name]
[Title]
[Company]

F. Opt-out Affidavit Termination Letter

If an eligible practitioner timely terminates his/her initial opt-out, the MACs shall acknowledge this action by using this model letter. If the eligible practitioner requests a cancellation, the MACs shall indicate the date of the cancellation and remove the following paragraph regarding termination. If the eligible practitioner terminates the opt-out, the MACs shall remove the cancellation language.

Month DD, YYYY

[Eligible Practitioner Name]

[Address]

[City] ST [Zip]

Reference: Case/Control Number

Dear [Eligible Practitioner Name]:

[Insert MAC] completed your request to terminate your Medicare opt-out affidavit.

Want to enroll as a Medicare billing provider or for the sole purpose of ordering and referring? Submit the appropriate Provider Enrollment Chain and Ownership System (PECOS) application or paper CMS-855 form.

APPEAL RIGHTS

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination.

Reconsideration requests must:

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the eligible practitioner that has been reported on your opt-out affidavit or an authorized representative.
 - If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the eligible practitioner is sufficient to accept this individual as the representative.
 - If the authorized representative is not an attorney, the eligible practitioner, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.

Eligible practitioners may:

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.
- Include an email address if you want to receive correspondence regarding your appeal via email.

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

[Centers for Medicare & Medicaid Services]
[Provider Enrollment & Oversight Group]
[ATTN: Division of Compliance & Appeals]
[7500 Security Blvd.]

[Mailstop: AR-18-50]
[Baltimore, MD 21244-1850]

Or emailed to:

[ProviderEnrollmentAppeals@cms.hhs.gov]

For questions concerning this letter, contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name]

[Title]

[Company]

G. Opt-out Affidavit Cancellation Letter

If an eligible practitioner timely submits an opt-out cancellation request, the MACs shall acknowledge this action by using this model letter.

Month DD, YYYY

[Eligible Practitioner Name]

[Address]

[City] ST [Zip]

Reference: Case/Control Number

Dear [Eligible Practitioner Name]:

[Insert MAC] completed your request to cancel your Medicare opt-out affidavit.

Your opt-out status will be canceled effective [Month DD, YYYY].

Want to enroll as a Medicare billing provider or for the sole purpose of ordering of referring? Submit the appropriate Provider Enrollment Chain and Ownership System (PECOS) application or paper CMS-855 form.

APPEAL RIGHTS

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination.

Reconsideration requests must:

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the eligible practitioner that has been reported on your opt-out affidavit or an authorized representative.
 - If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the eligible practitioner is sufficient to accept this individual as the representative.
 - If the authorized representative is not an attorney, the eligible practitioner, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.

Eligible practitioners may:

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.
- Include an email address if you want to receive correspondence regarding your appeal via email.

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

[Centers for Medicare & Medicaid Services]
[Provider Enrollment & Oversight Group]
[ATTN: Division of Compliance & Appeals]
[7500 Security Blvd.]
[Mailstop: AR-18-50]
[Baltimore, MD 21244-1850]

Or emailed to:

[ProviderEnrollmentAppeals@cms.hhs.gov]

For questions concerning this letter, contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name]

[Title]

[Company]

10.7.16 – Model Letters for Claims Against Surety Bonds

(Rev. 10524; Issued: 12-17-20; Effective: 11-13-20; Implementation: 11-13-20)

When making a claim against a surety bond in accordance with section 10.2.5(A)(2)(o)(ii) of this chapter, the contractor shall use the applicable model letter below:

A. Letter for Overpayments – Supplier is Still Enrolled in Medicare

Date

Surety Name

Surety Address

RE: Supplier Legal Business Name
 Supplier DBA Name (if any)
 Supplier Address
 Supplier National Provider Identifier (NPI)

Dear Surety:

(Supplier legal business name) is currently enrolled in the Medicare program as a supplier of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). As a condition of its Medicare enrollment, (Supplier) is required – under Federal regulations at 42 C.F.R. §424.57(d) - to maintain a surety bond in an amount of no less than \$50,000. In accordance with this provision, (Supplier) has a \$_____ surety bond with your company.

Consistent with 42 C.F.R. §424.57(d)(5)(i)(A), the surety must pay CMS - upon receiving written notice from CMS containing “sufficient evidence” as defined in the Program Integrity Manual, CMS Pub. 100-08, §10.2.5(A)(3)(b) - the amount of any unpaid claim for which the DMEPOS supplier is responsible, up to the full penal amount of the bond. An “unpaid claim” is defined in 42 C.F.R. §424.57(a) as an overpayment made by the Medicare program to the DMEPOS supplier for which the DMEPOS supplier is responsible.

CMS has determined that (Supplier) has incurred an overpayment in the amount of (insert dollar amount) for (insert “a service” or “services”, as applicable) performed on (insert date(s) of service). This determination was made based on specific information about the overpayment, which is included in the attachments to this letter.

CMS has been unable to recover the full overpayment from (Supplier) using its existing recoupment procedures. (Supplier) has repaid (insert "none" or "only \$ _____") of the overpayment amount. Consistent with 42 C.F.R. §424.57(d)(5)(i)(A), therefore, CMS requests that (Surety) make payment to CMS in the amount of (insert applicable amount) no later than 30 days from the date of this letter. Payment shall be made via check or money order and sent to the following address:

Contractor Name

Address

City, State and Postal ZIP Code

The payee shall be (insert DME MAC), which is CMS's Durable Medical Equipment Medicare Administrative Contractor for (Supplier)'s location.

Failure to make the requested payment in a timely manner may result in referrals to the United States Department of Justice for collection action, and/or the United States Department of the Treasury for revocation of [surety name's] authority to provide federal bonds.

Should you have any questions about this letter, please do not hesitate to contact _____ at _____. (The contractor shall identify a specific individual who the surety can contact if questions arise.)

Sincerely,
(Name and title)

cc: Supplier Name

B. Letter for Overpayments - Supplier is No Longer Enrolled in Medicare

Date

Surety Name

Surety Address

RE: Former Supplier Legal Business Name
Former Supplier DBA Name (if any)
Former Supplier Address
Former Supplier NPI

Dear Surety:

(Former Supplier legal business name) was enrolled in the Medicare program as a supplier of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) until (insert effective date of termination/revocation). As a condition of its Medicare enrollment, (Former Supplier) was required – under Federal regulations at 42 C.F.R. §424.57(d) - to maintain a surety bond in an amount of no less than \$50,000. In accordance with this provision, (Former Supplier) obtained a \$ _____ surety bond with your company.

Consistent with 42 C.F.R. §424.57(d)(5)(i)(A), the surety must pay CMS – upon receiving written notice from CMS containing sufficient evidence to establish the surety’s liability under the bond – the amount of any unpaid claim for which the DMEPOS supplier is responsible, up to the full penal amount of the bond. An “unpaid claim” is defined in 42 C.F.R. §424.57(a) as an overpayment made by the Medicare program to the DMEPOS supplier for which the DMEPOS supplier is responsible.

CMS has determined that (Supplier) incurred an overpayment in the amount of (insert dollar amount) for (insert “a service” or “services”, as applicable) performed on (insert date(s) of service). This determination was made based on specific information about the overpayment, which is included in the attachments to this letter.

CMS has been unable to recover the full overpayment from (Former Supplier) using its existing recoupment procedures. (Former Supplier) has repaid (insert “none” or “only \$ _____) of the overpayment amount.

(Former Supplier’s) surety bond coverage with your company ended on (insert date). However, consistent with 42 C.F.R. §424.57(d)(5)(iii), the surety is liable for unpaid claims that:

- CMS assessed against the supplier based on overpayments that took place during the term of the bond or rider, and
- Were assessed by CMS during the 2 years following the date that the supplier failed to submit a bond or required rider or the date that the supplier’s Medicare enrollment was terminated, whichever is later.

The overpayment occurred on (insert date), which was within the period of (Former Supplier)’s surety bond coverage with your company. Moreover, CMS has made its overpayment determination within the 2-year period following the date of the termination of (Former Supplier)’s Medicare enrollment. Consistent with 42 C.F.R. §424.57(d)(5)(i)(A), therefore, CMS requests that (Surety) make payment to CMS in the amount of (insert applicable amount) no later than 30 days from the date of this letter. Payment shall be made via check or money order and sent to the following address:

Contractor Name
Address
City, State and Postal ZIP Code

The payee shall be (insert DME MAC), which is CMS's Durable Medical Equipment Medicare Administrative Contractor for (Supplier)'s location.

Failure to make the requested payment in a timely manner may result in referrals to the United States Department of Justice for collection action, and/or the United States Department of the Treasury for revocation of [surety name's] authority to provide federal bonds.

Should you have any questions about this letter, please do not hesitate to contact _____ at _____. (The contractor shall identify a specific individual who the surety can contact if questions arise.)

Sincerely,
(Name and title)

cc: Supplier Name

C. Letter for Civil Monetary Penalties and Assessments – Supplier is Still Enrolled in Medicare

Date

Surety Name
Surety Address

RE: Supplier Legal Business Name
Supplier DBA Name (if any)
Supplier Address
Supplier NPI

Dear Surety:

(Supplier legal business name) is currently enrolled in the Medicare program as a supplier of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). As a condition of its Medicare enrollment, (Supplier) is required – under Federal regulations at 42 C.F.R. §424.57(d) - to maintain a surety bond in an amount of no less than \$50,000. In accordance with this provision, (Supplier) has a \$_____ surety bond with your company.

Consistent with 42 C.F.R. §424.57(d)(5)(i)(A), the surety must pay CMS – upon receiving written notice from CMS containing sufficient evidence to establish the surety's liability under the bond – the amount of any civil monetary penalty (CMP) and/or assessment for which the DMEPOS supplier is responsible, up to the full penal amount of the bond. (Insert applicable language.....)

A CMP is defined in §424.57(a) as a sum that CMS has the authority, as implemented by 42 C.F.R. §402.1(c) (or the Department of Health and Human Services Office of Inspector General (OIG)) has the authority, under section 1128A of the Act or 42 C.F.R. Part 1003) to impose on a supplier as a penalty.

OR

An assessment is defined as a sum certain that CMS or the Department of Health and Human Services Office of Inspector General (OIG) may assess against a DMEPOS supplier under Titles XI, XVIII or XXI of the Social Security Act.)

(CMS or OIG, as applicable) imposed a (CMP and/or assessment, as applicable) on (Supplier) on (date) in the amount of (\$ ____). The (CMP and/or assessment) was imposed because (insert explanation, using information furnished by CMS or OIG).

Relevant documentation supporting our determination is attached to this letter. (Attach copy of notice of CMP/assessment that was sent to supplier.)

(CMS or OIG, as applicable) has attempted to recover the amount of the (CMP or assessment) from (Supplier) using its existing collection procedures. (Supplier), however, has repaid (insert “none” or “only \$ ____”) of this amount. Consistent with 42 C.F.R. §424.57(d)(5)(i)(A), therefore, CMS requests that (Surety) make payment to CMS in the amount of (insert applicable amount) no later than 30 days from the date of this letter. Payment shall be made via check or money order and sent to the following address:

Contractor Name
Address
City, State and Postal ZIP Code

The payee shall be the Centers for Medicare and Medicaid Services.

Failure to make the requested payment in a timely manner may result in referrals to the United States Department of Justice for collection action, and/or the United States Department of the Treasury for revocation of [surety name’s] authority to provide federal bonds.

Should you have any questions about this letter, please do not hesitate to contact _____ at _____. (The contractor shall identify a specific individual who the surety can contact if questions arise.)

Sincerely,
(Name and title)

cc: Supplier Name

D. Letter for Civil Monetary Penalties and Assessments – Supplier is No Longer Enrolled in Medicare

Date

Surety Name

Surety Address

RE: Former Supplier Legal Business Name
Former Supplier DBA Name (if any)
Former Supplier Address
Former Supplier NPI

Dear Surety:

(Former Supplier legal business name) was enrolled in Medicare as a supplier of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) until (insert effective date of termination/revocation). As a condition of its Medicare enrollment, (Former Supplier) was required – under Federal regulations at 42 C.F.R. §424.57(d) - to maintain a surety bond in an amount of no less than \$50,000. In accordance with this provision, (Former Supplier) obtained a \$_____ surety bond with your company.

Consistent with 42 C.F.R. §424.57(d)(5)(i)(A), the surety must pay CMS – upon receiving written notice from CMS containing sufficient evidence to establish the surety’s liability under the bond – the amount of any civil monetary penalty (CMP) and/or assessment for which the DMEPOS supplier is responsible, up to the full penal amount of the bond. (Insert applicable language.....

A CMP is defined in §424.57(a) as a sum that CMS has the authority, as implemented by 42 C.F.R. §402.1(c) (or the Department of Health and Human Services Office of Inspector General (OIG) has the authority, under section 1128A of the Act or 42 C.F.R. Part 1003)) to impose on a supplier as a penalty.

OR

An assessment is defined as a sum certain that CMS or the Department of Health and Human Services Office of Inspector General (OIG) may assess against a DMEPOS supplier under Titles XI, XVIII or XXI of the Social Security Act.)

(CMS or OIG, as applicable) imposed a (CMP and/or assessment, as applicable) on (Former Supplier) on (date) in the amount of (\$ _____). The (CMP and/or assessment) was imposed because (insert explanation, using information furnished by CMS or OIG).

Relevant documentation supporting our determination is attached to this letter. (Attach copy of notice of CMP/assessment that was sent to former supplier.)

(CMS or OIG, as applicable) has attempted to recover the amount of the (CMP or assessment) from (Former Supplier) using its existing collection procedures. (Former Supplier), however, has repaid (insert “none” or “only \$_____”) of this amount.

(Former Supplier)’s surety bond coverage with your company ended on (insert date). However, consistent with 42 C.F.R. §424.57(d)(5)(iii), the surety is liable for CMPs and/or assessments that:

- CMS or OIG imposed or asserted against the supplier during the term of the bond or rider, and
- Were imposed or assessed by CMS during the 2 years following the date that the supplier failed to submit a bond or required rider or the date that the supplier’s Medicare enrollment was terminated, whichever is later.

The (CMP and/or assessment) was based on events that occurred (insert relevant date(s)), which was within the period of (Former Supplier’s) surety bond coverage with your company. Moreover, CMS imposed the (CMP and/or assessment) within the 2-year period following the date of the termination of (Former Supplier)’s Medicare enrollment. Consistent with 42 C.F.R. §424.57(d)(5)(i)(A), therefore, CMS requests that (Surety) make payment to CMS in the amount of (insert applicable amount) no later than 30 days from the date of this letter. Payment shall be made via check or money order and sent to the following address:

Contractor Name
Address
City, State and Postal ZIP Code

The payee shall be the Centers for Medicare & Medicaid Services.

Failure to make the requested payment in a timely manner may result in referrals to the United States Department of Justice for collection action, and/or the United States Department of the Treasury for revocation of [surety name’s] authority to provide federal bonds.

Should you have any questions about this letter, please do not hesitate to contact _____ at _____. (The contractor shall identify a specific individual who the surety can contact if questions arise.)

Sincerely,
(Name and title)

cc: Supplier Name

E. Surety Non-Payment Letter

Date

Surety Name

Surety Address

RE: Supplier Legal Business Name
Supplier DBA Name (if any)
Supplier Address
Supplier National Provider Identifier (NPI)

Dear Surety:

Consistent with 42 C.F.R. §424.57(d)(5)(i)(A), we sent you a letter dated (date of letter) requesting that you make payment to CMS in the amount of (insert applicable amount) no later than 45 days from the date of said letter, a copy of which is attached. (Attach a copy of the demand letter.) As payment has not been received, this matter may be referred for further action to the United States Department of Justice for collection and/or the United States Department of the Treasury for revocation of [surety name's] authority to provide federal bonds.

Should you have any questions about this letter, please do not hesitate to contact _____ at _____. (The contractor shall identify a specific individual who the surety can contact if questions arise.)

Sincerely,
(Name and title)

cc: Supplier Name

10.7.15 –Revalidation Notification Letters
(Rev. 10611; Issued: 03-19-21; Effective:11-19-20; Implementation:
11-19-20)

A. Revalidation Letter

REVALIDATION

[month] [day], [year]

[Provider/Supplier Name]
[Address]
[City], [State] [Zip Code]

Dear [Provider/Supplier Name],

Every five years, CMS requires you to revalidate your Medicare enrollment record. You need to update or confirm all the information in your record, including your practice locations and reassignments.

We need this from you by **[Due date, as Month dd yyyy]**. If we don't receive your response by then, we may stop your Medicare billing privileges.

If you are a non-certified provider or supplier, and your enrollment is deactivated, you will maintain your original PTAN, however will not be paid for services rendered during the period of deactivation. This will cause a gap in your reimbursement.

What record needs revalidating by [Due date, as Month dd yyyy]

[Name] | **NPI** [NPI] | **PTAN** [PTAN]

Reassignments: <Only include this title if the record has any reassignments>

[Legal Business Name] | [dba Name] | Tax ID [Tax ID, mask all but last 4 digits]

<Repeat for other reassignments>

CMS lists the records that need revalidating at go.cms.gov/MedicareRevalidation.

What you need to do

Revalidate your Medicare enrollment record, through
<https://pecos.cms.hhs.gov/pecos/login.do> or [form CMS-855 or Form CMS-20134].

- **Online:** PECOS is the fastest option. If you don't know your username or password, PECOS offers ways to retrieve them. Our customer service can also help you by phone at 866-484-8049.
- **Paper:** Download the right version of form [CMS-855 or Form CMS-20134] for your situation at cms.gov. We recommend getting proof of receipt for your mailing. Mail to [contractor address].

If you have a fee due, use PECOS to pay. If you feel you qualify for a hardship waiver, mail us a request on practice letterhead with financial statements, application form, and certification. For more on fees and exceptions, search cms.gov for "CR 7350" or "Fee Matrix".

A new Electronic Funds Transfer (EFT) Authorization Form (CMS-588) is only required to be submitted as part of your revalidation package if the current version, approved by the Office of Management and Budget (OMB), is not on file with Medicare. The current version of the form can be found at <http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS588.pdf>.

If you need help

Visit go.cms.gov/MedicareRevalidation

Call [contractor phone #] or visit [contractorsite.com] for more options.

Sincerely,

[Name]

[Title]

[Company]

B. Revalidation Letter – CHOW Scenario Only

[month] [day], [year]

PROVIDER/SUPPLIER NAME

ADDRESS 1, ADDRESS 2

CITY STATE ZIP CODE

NPI:

PTAN:

Dear Provider/Supplier Name:

**THIS IS A PROSPECTIVE PROVIDER ENROLLMENT REVALIDATION
REQUEST**

**IMMEDIATELY SUBMIT AN UPDATED
PROVIDER ENROLLMENT PAPER APPLICATION 855 FORM TO VALIDATE
YOUR ENROLLMENT INFORMATION**

In accordance with Section 6401 (a) of the Patient Protection and Affordable Care Act, all new and existing providers must be reevaluated under the new screening guidelines. Medicare requires all enrolled providers and suppliers to revalidate their enrollment information every five years (reference 42 CFR §424.515). To ensure compliance with these requirements, existing regulations at 42 CFR §424.515(d) provide that the Centers for Medicare & Medicaid Services (CMS) is permitted to conduct off-cycle revalidations for certain program integrity purposes. Upon the CMS request to revalidate its enrollment, the provider/supplier has 60 days from the post mark date of this letter to submit complete enrollment information.

You previously submitted a change of ownership (CHOW) application that is currently being reviewed by the CMS Regional Office (RO) and the State Agency. Since your application has not been finalized, please validate that we have the most current information on file. Any updated information received since your initial submission will be forwarded to the CMS RO and the State Agency for their final determination.

Providers and suppliers can validate their provider enrollment information using the paper application form. To validate by paper, download the appropriate and current CMS-855 Medicare Enrollment application from the CMS Web site at

<https://www.cms.gov/MedicareProviderSupEnroll/>. Mail your completed application and all required supporting documentation to the [insert contractor name], at the address below.

[Insert application return address]

A new Electronic Funds Transfer (EFT) Authorization Form (CMS-588) is only required to be submitted as part of your revalidation package if the current version, approved by the Office of Management and Budget (OMB), is not on file with Medicare. The current version of the form can be found at <http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS588.pdf>.

If additional time is required to complete the validation applications, you may request one 60-day extension, which will be added onto the initial 60 days given to respond to the request. The request may be submitted in writing from the individual provider, the Authorized or Delegated Official of the organization or the contact person and addressed to the MAC(s). The request should include justification of why a 60-day extension is needed. The request may also be made by contacting your MAC(s), via phone.

Physicians, non-physician practitioners and physician and non-physician practitioner organizations must report a change of ownership, any adverse legal action, or a change of practice location to the MAC within 30 days. All other changes must be reported within 90 days. For most but not all other providers and suppliers, changes of ownership or control, including changes in authorized official(s) must be reported within 30 days; all other changes to enrollment information must be made within 90 days.

Failure to submit complete enrollment application(s) and all supporting documentation within 60 calendar days of the postmark date of this letter may result in your Medicare billing privileges being deactivated and your CHOW not being processed. We strongly recommend you mail your documents using a method that allows for proof of receipt.

If you have any questions regarding this letter, please call [contractor telephone number will be inserted here] between the hours of [contractor telephone hours will be inserted here] or visit our Web site at [insert Web site] for additional information regarding the enrollment process or the [insert application type].

Sincerely,
[Your Name]
[Title]

C. Large Group Revalidation Notification Letter

[month] [day], [year]

PROVIDER/SUPPLIER GROUP NAME

NPI:

ADDRESS 1, ADDRESS 2
CITY STATE ZIP CODE

PTAN:

Dear Provider/Supplier Group Name:

THIS IS NOT A PROVIDER ENROLLMENT REVALIDATION REQUEST

This is to inform you that a number of physicians and/or non-physician practitioners reassigning all or some of their benefits to your group have been selected for revalidation. For your convenience, a list of those individuals is attached. A revalidation notice will be sent to the physician or non-physician practitioner within the next seven months. They will need to respond by the revalidation due date provided for each provider. It is the responsibility of the physician and/or non-physician practitioner to revalidate all their Medicare enrollment information and not just that associated with the reassignment to your group practice.

In accordance with Section 6401 (a) of the Patient Protection and Affordable Care Act, all new and existing providers must be reevaluated under the new screening guidelines. Medicare requires all enrolled providers and suppliers to revalidate their enrollment information every five years (reference 42 CFR §424.515). To ensure compliance with these requirements, existing regulations at 42 CFR §424.515(d) provide that the Centers for Medicare & Medicaid Services (CMS) is permitted to conduct off-cycle revalidations for certain program integrity purposes.

Physicians and non-physician practitioners can revalidate by using either Internet-based PECOS or submitting a paper CMS-855 enrollment application. Failure to submit a complete revalidation application and all supporting documentation within 60 calendar days may result in the physician or non-physician practitioner's Medicare billing privileges being deactivated. As such, your group will no longer be reimbursed for services rendered by the physician or non-physician practitioner.

If you have any questions regarding this letter, please call [contractor telephone number will be inserted here] between the hours of [contractor telephone hours will be inserted here] or visit our Web site at [insert Web site] for additional information regarding the revalidation process.

Sincerely,

[Your Name]
[Title]

D. Revalidation Pend Letter

PAYMENT HOLD

[month] [day], [year]

[Provider/Supplier Name]

[Address]

[City], [State] [Zip Code]

Dear [Provider/Supplier Name],

We are holding all payments on your Medicare claims, because you haven't revalidated your enrollment record with us. This does not affect your Medicare participation agreement, or any of its conditions.

Every [three or five years], CMS requires you to revalidate your Medicare enrollment record information. You need to update or confirm all the information in your record, including your practice locations and reassignments.

Failure to respond to this notice will result in a possible deactivation of your Medicare enrollment. If you are a non-certified provider or supplier, and your enrollment is deactivated, you will maintain your original PTAN, however will not be paid for services rendered during the period of deactivation. This will cause a gap in your reimbursement.

What record needs revalidating

[Name] | **NPI** [NPI] | **PTAN** [PTAN]

Reassignments:

[Legal Business Name] | [dba Name] | Tax ID [Tax ID, mask all but last 4 digits]

<Repeat for other reassignments>

CMS lists the records that need revalidating at **go.cms.gov/MedicareRevalidation**.

How to resume your payments

Revalidate your Medicare enrollment record, through

<https://pecos.cms.hhs.gov/pecos/login.do> or [form CMS-855 or Form CMS-20134].

- **Online:** PECOS is the fastest option. If you don't know your username or password, PECOS offers ways to retrieve them. Our customer service can also help you by phone at 866-484-8049.
- **Paper:** Download the right version of [form CMS-855 or Form CMS-20134] for your situation at cms.gov. We recommend getting proof of receipt for your mailing. Mail to [contractor address].

If you have a fee due, use PECOS to pay. If you feel you qualify for a hardship waiver, mail us a request on practice letterhead with financial statements, application form, and certification.

If you need help

Visit **go.cms.gov/MedicareRevalidation**

Call [contractor phone #] or visit [contractorsite.com] for more options.

Sincerely,

[Name]

[Title]

[Company]

E. Revalidation Deactivation Letter**STOPPING BILLING PRIVILEGES**

[month] [day], [year]

[Provider/Supplier Name]

[Address]

[City], [State] [Zip Code]

Dear [Provider/Supplier Name],

Your Medicare billing privileges are being deactivated effective [Month] [DD], [YYYY], pursuant to 42 C.F.R. § 424.540(a)(3) because you have not timely revalidated your enrollment record with us, or your revalidation application has been rejected because you did not timely respond to our requests for more information. We will not pay any claims after this date.

Every five years [three for the NSC], CMS requires you to revalidate your Medicare enrollment record.

What record needs revalidating

[Name] | **NPI** [NPI] | **PTAN** [PTAN]

Reassignments:

[Legal Business Name] | [dba Name] | Tax ID [Tax ID, mask all but last 4 digits]

<Repeat for other reassignments>

CMS lists the records that need revalidating at

<https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Revalidations.html>.

REBUTTAL RIGHTS:

If you believe that this determination is not correct, you may rebut the deactivation as indicated in 42 C.F.R. § 424.545. The rebuttal must be received by this office in writing within 20 calendar days of the date of this letter. The rebuttal must state the issues or findings of fact with which you disagree and the reasons for disagreement. You may

submit additional information with the rebuttal that you believe may have a bearing on the decision. You must submit all information that you would like to be considered in conjunction with the rebuttal. This includes any application(s) to update your enrollment, if necessary. You may only submit one rebuttal in response to this deactivation of your Medicare enrollment.

The rebuttal must be signed and dated by the individual provider/supplier, the authorized or delegated official, or a legal representative.

If the provider/supplier wishes to appoint a legal representative that is not an attorney to sign the rebuttal, the provider/supplier must include with the rebuttal a written notice authorizing the legal representative to act on the provider/supplier's behalf. The notice should be signed by the provider/supplier.

If the provider/supplier has an attorney sign the rebuttal, the rebuttal must include a statement from the attorney that he/she has the authority to represent the provider/supplier.

If you wish to receive communication regarding your rebuttal via email, please include a valid email address in your rebuttal request.

The rebuttal should be sent to the following:

[MAC Rebuttal Receipt Address]
[MAC Rebuttal Receipt Email Address]
[MAC Rebuttal Receipt Fax Number]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

How to recover your billing privileges

Revalidate your Medicare enrollment record, through [PECOS.cms.hhs.gov](https://pecos.cms.hhs.gov), or [form CMS-855 or Form CMS-20134].

- Online: PECOS is the fastest option. If you don't know your username or password, PECOS offers ways to retrieve them. Our customer service can also help you by phone at 866-484-8049.
- Paper: Download the right version of [form CMS-855 or Form CMS-20134] for your situation at cms.gov. We recommend getting proof of receipt for your mailing. Mail to [contractor address].

If you have a fee due, use PECOS to pay. If you feel you deserve a hardship waiver, mail us a request on practice letterhead with financial statements, application form, and certification.

If you are a non-certified provider or supplier, and your enrollment is deactivated, you will maintain your original PTAN, however will not be paid for services rendered during the period of deactivation. This will cause a gap in your reimbursement.

If you need help

Visit <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Revalidations.html>.

Call [contractor telephone number] or visit [contractorsite.com] for more options.

Sincerely,

[Name]

[Title]

[Company]

F. Revalidation Past-Due Group Member Letter

REVALIDATION | Past-Due Group Member

[month] [day], [year]

[Provider/Supplier Name]

[Address]

[City], [State] [Zip Code]

Dear [Provider/Supplier Name],

Every five years, CMS requires providers to revalidate their Medicare enrollment records. You have not revalidated by the requested due date of [revalidation due date].

You need to update or confirm all the information in your record, including your practice locations and reassignments. If you are a non-certified provider or supplier, and your enrollment is deactivated, you will maintain your original PTAN, however will not be paid for services rendered during the period of deactivation. This will cause a gap in your reimbursement.

If multiple records below need to be revalidated, please coordinate with the appropriate parties to provide only one response.

What record needs revalidating

[Name] | **NPI** [NPI] | **PTAN** [PTAN]

Reassignments: <Only include this title if the record has any reassignments>

[Legal Business Name] | [dba Name] | Tax ID [Tax ID, mask all but last 4 digits]

<Repeat for other reassignments>

CMS lists the records that need revalidating at [go.cms.gov/MedicareRevalidation](https://www.cms.gov/MedicareRevalidation).

What your group member needs to do

Revalidate their Medicare enrollment record, through <https://pecos.cms.hhs.gov/pecos/login.do>. or [form CMS-855 or Form CMS-20134].

- **Online:** PECOS is the fastest option. If they don't know their username or password, PECOS offers ways to retrieve them. Our customer service can also help by phone at 866-484-8049.
- **Paper:** Download the right version of [form CMS-855 or Form CMS-20134] for their situation at cms.gov. We recommend getting proof of receipt for this mailing. Mail to [contractor address].

If your group member needs help

Visit go.cms.gov/MedicareRevalidation

Call [contractor phone #] or visit [contractorsite.com] for more options.

Sincerely,

[Name]

[Title]

[Company]

G. Model Return Revalidation Letter

RETURN REVALIDATION

[month] [day], [year]

[Provider/Supplier Name]

[Address]

[City], [State] [Zip Code]

Dear [Provider/Supplier Name],

Your Medicare enrollment application(s) was received on [date]. We are closing this request and returning your application(s) for the following reason(s):

- The [form CMS-855 or Form CMS-20134] application received by [PROVIDER/SUPPLIER NAME] was unsolicited.
 - An unsolicited revalidation is one that is received more than seven months prior to the provider/supplier's due date. Due dates are established around 5 years from the provider/suppliers last successful revalidation or their initial enrollment.
 - To find the provider/suppliers revalidation due date, please go to <http://go.cms.gov/MedicareRevalidation>.
 - If you are not due for revalidation in the current seven month period, you will find that your due date is listed as "TBD" (or To Be Determined). This means that you do not yet have a due date for

revalidation within the current seven month period. This list will be updated monthly.

- If your intention is to change information on your Medicare enrollment file, you must complete a new Medicare enrollment application(s) and mark 'change' in section 1 of the [form CMS-855 or Form CMS-20134].
- Please address the above issues as well as sign and date the new certification statement page on your resubmitted application(s).

Providers and suppliers can apply to enroll in the Medicare program using one of the following two methods:

1. Internet-based Provider Enrollment, Chain and Organization System (PECOS). Go to: <https://pecos.cms.hhs.gov/pecos/login.do>.

2. Paper application process: Download and complete the Medicare enrollment application(s) at <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/EnrollmentApplications.html>. DMEPOS suppliers should send the completed application to the National Supplier Clearinghouse (NSC).

If you need help

Visit <http://go.cms.gov/MedicareRevalidation>, or

Call [contractor phone #] or visit [contractorsite.com] for more options.

Sincerely,

[Name]

[Title]

[Company]

10.7.17 – Model Identity Theft Prevention Letter

(Rev. 10611; Issued: 03-19-21; Effective:11-19-20; Implementation: 11-19-20)

[month] [day], [year]

[Provider/Supplier Name]

[Address]

[City] ST [Zip]

Reference # (PTAN #, Enrollment #, Case #, etc.)

Dear [Provider/Supplier Name]:

As a security precaution, we are writing to confirm that you submitted a Medicare enrollment application(s) to enroll in or change an existing enrollment at the following address:

[Provider/Supplier Name]
[Address]
[City] ST [Zip]

If this application was submitted without your authorization, please contact the Medicare contractor that processes your claims immediately. The Medicare Fee-For-Service contact information can be found at www.cms.hhs.gov/MedicareProviderSupEnroll.

We will process your application(s) according to The Centers for Medicare & Medicaid (CMS) timeliness standards and will contact you if additional information is needed. We will notify you once processing is complete.

Please contact our office with any questions at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM] and refer to your application(s) reference number [Reference number]

Sincerely,

[Name]
[Title]
[Company]

10.7.18 - Model Documentation Request Letter

(Rev. 10611; Issued: 03-19-21; Effective:11-19-20; Implementation: 11-19-20)

A. Model Language for §424.516(f)(1) Situations

The contractor shall use the model language below if it is requesting documentation from a provider or supplier furnishing the items or services addressed in §424.516(f)(1).

“Dear Provider/Supplier:

Under 42 CFR §424.516(f)(1), a provider or supplier that furnishes covered ordered items of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS), clinical laboratory, imaging services, or covered ordered/certified home health services is required to:

- Maintain documentation for 7 years from the date of service, and

- Upon the request of CMS or a Medicare contractor, provide access to that documentation.

The documentation to be maintained includes written and electronic documents (including the National Provider Identifier (NPI) of the physician who ordered/certified the home health services and the NPI of the physician - or, when permitted, other eligible professional - who ordered items of DMEPOS or clinical laboratory or imaging services) relating to written orders and certifications and requests for payments for items of DMEPOS and clinical laboratory, imaging, and home health services.

Consistent with §424.516(f)(1), please mail to us copies of the orders for the items or services that were furnished to the following beneficiaries on the dates specified:

(Contractors shall insert the beneficiaries' names (up to 5 may be listed, unless CMS specifies otherwise), appropriate identification information, and the dates on which the provider or supplier furnished the items/services in question. The contractor has the discretion to determine the cases/services that are included in this documentation request as well as the type(s) of documentation to be requested.)

The documentation must be received at the following address no later than 30 calendar days after the date of this letter:

(Cite appropriate address)

Failure to timely submit this documentation may result in the revocation of your enrollment pursuant to 42 CFR §424.535(a)(10)."

Please contact our office with any questions at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM] and refer to your application(s) reference number [Reference number]

Sincerely,

[Name]

[Title]

[Company]

B. Model Language for §424.516(f)(2) Situations

The contractor shall use the model language below if it is requesting documentation from a provider or supplier furnishing the items or services addressed in § 424.516(f)(2).

"Dear Physician/Professional:

Under 42 CFR §424.516(f)(2), a physician who orders/certifies home health services and the physician - or, when permitted, other eligible professional - who orders items of DMEPOS or clinical laboratory or imaging services is required to maintain documentation for 7 years from the date of service and to provide access to that documentation pursuant to a CMS or Medicare contractor request. The documentation to be maintained includes written and electronic documents relating to written orders and certifications and requests for payments for items of DMEPOS and clinical laboratory, imaging, and home health services.

Consistent with §424.516(f)(2), please mail to us copies of the orders for items or services that you issued for the following beneficiaries on the dates specified:

(Contractors shall insert the beneficiaries' names (up to 5 may be listed, unless CMS specifies otherwise), appropriate identification information, and the dates on which the orders were made. The contractor has the discretion to determine the cases/services that are included in this documentation request as well as the type(s) of documentation to be requested.)

The documentation must be received at the following address no later than 30 calendar days after the date of this letter:

(Cite appropriate address)

Failure to timely submit this documentation may result in the revocation of your enrollment pursuant to 42 CFR §424.535(a)(10).” (For individuals enrolled via the Form CMS-855O, the contractor shall instead use the following language: “Failure to timely submit this documentation may result in the revocation of your Form CMS-855O enrollment.”)

Please contact our office with any questions at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM] and refer to your application(s) reference number [Reference number]

Sincerely,

[Name]

[Title]

[Company]

10.7.19 – Model Approval Letter for Federally Qualified Health Centers (FQHCs)

(Rev. 10672; Issued: 03-18-21; Effective: 03-12-21; Implementation: 03-22-21)

This section 10.7.19 contains an FQHC model approval letter that contractors shall use as directed in section 10.2.1(D) of this chapter. This letter takes precedence over all other letters in section 10.7 et seq. that pertain to approval of certified providers and certified suppliers. The contractor shall continue to use existing certified provider/supplier model letters for all other FQHC transactions (e.g., revalidations).

FQHC Approval Letter

[Month, Day, Year]

[FQHC Name]

[Address]

[City, State, Zip]

Reference # (Application Tracking Number)

Dear [FQHC],

[Insert Contractor] has approved your enrollment as a federally qualified health center (FQHC).

Medicare Enrollment Information

| | |
|--|--|
| Legal Business Name (LBN) | |
| Doing Business As (DBA) | |
| Physical Location Address | |
| National Provider Identifier (NPI) | |
| Provider Transaction Access Number (PTAN)/CMS Certification Number (CCN) | |
| PTAN/CCN Effective Date | |
| Medicare Year-End Cost Report Date | |

Included with this letter is a copy of your “Attestation Statement for Federal Qualified Health Center” (Exhibit 177), which CMS has signed.

Your PTAN is the authentication element for all inquiries to customer service representatives (CSRs), written inquiry units, and the interactive voice response (IVR) system.

Contact our electronic data interchange (EDI) department for enrollment and further instructions on electronic claims filing at [phone number].

Enroll, make changes to, or view your existing enrollment information by logging into PECOS at <https://pecos.cms.hhs.gov>.

Submit updates and changes to your enrollment information within the timeframes specified at 42 CFR § 424.516. For more information on the reporting requirements, go to Medicare Learning Network Article SE1617.

Find additional Medicare program information, including billing, fee schedules, and Medicare policies and regulations at [insert contractor's web address] or <https://www.cms.gov>.

Right to Submit a Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. (Optional Coversheet sentence [To facilitate the processing of your reconsideration request, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.]])

Reconsideration requests must:

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
 - If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
 - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.
 - Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her behalf.

Providers and suppliers may:

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to

submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.

- Include an email address if you want to receive correspondence regarding your appeal via email.

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

Centers for Medicare & Medicaid Services
Provider Enrollment & Oversight Group
ATTN: Division of Compliance & Appeals
7500 Security Blvd.
Mailstop: AR-19-51
Baltimore, MD 21244-1850

Or emailed to:

ProviderEnrollmentAppeals@cms.hhs.gov

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Name]

[Title]

[Company]

***10.7.20 – Model Approval Letter for Voluntary Terminations
Involving Certified Providers and Certified Suppliers
(Rev. 10740; Issued: 05-07-21; Effective: 03-26-21; Implementation: 06-07-21)***

This section 10.7.20 contains a model approval letter for certified provider/supplier voluntary terminations pursuant to section 10.6.1.3 of this chapter. For the situations in section 10.6.1.3, this model letter take precedence over all others in this chapter.

The contractor may modify this letter as needed to address unique circumstances associated with the case.

[Month, Day, Year]

[Provider/Supplier Name]
[Address]
[City, State, Zip]

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

*[Insert Contractor] has received notification from the State Agency that you are voluntarily terminating your provider/supplier agreement **or** [Insert Contractor] has completed processing your application [or letter] to voluntarily disenroll from the Medicare program. Therefore, your provider agreement has been terminated and your Medicare provider enrollment deactivated effective on the dates shown below.*

Medicare Termination-Deactivation Information

Legal Business Name (LBN):
Doing Business As (DBA):
Address: (if different from mailing address)
Provider/Supplier Type:
National Provider Identifier (NPI):
Provider Transaction Access Number (PTAN)/CCN:
Reason for Termination:
Effective Date of Provider Agreement Termination:
Effective Date of Medicare Provider Enrollment Deactivation:

Medicare will not reimburse you for any claims with dates of service on or after the effective date of the termination of your provider agreement except as permitted under 42 CFR §489.55.

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Name]
[Title]
[Company]

[CC: CMS Location; State Agency; AO (if applicable)]

Transmittals Issued for this Chapter

| Rev # | Issue Date | Subject | Impl Date | CR# |
|-----------------|-------------------|--|------------------|------------|
| <u>R10740PI</u> | 05/07/2021 | Voluntary Terminations of Enrollment Involving Certified Providers and Certified Suppliers | 06/07/2021 | 12160 |
| <u>R10735PI</u> | 04/27/2021 | Updates to Medicare Administrative Contractor (MAC) Appeals and Rebuttals Reporting | 05/27/2021 | 12157 |
| <u>R10727PI</u> | 04/13/2021 | Chapter 15 of Publication (Pub.) 100-08 Manual Redesign – Additional Release of Chapter 10 of Pub. 100-08, Modification of the Timeliness Standards | 02/01/2021 | 11865 |
| <u>R10723PI</u> | 04/08/2021 | Implementation of Provider Enrollment Provisions in CMS-6058-FC – Phase 1 – Continued Removal/Moving of Instructions from Chapter 15 of Publication (Pub.) 100-08 to Chapter 10 of Pub. 100-08 | 08/10/2020 | 11551 |
| <u>R10672PI</u> | 03/18/2021 | First General Update to Chapter 10 of Publication (Pub.) 100-08, Program Integrity Manual (PIM) | 03/18/2021 | 12149 |
| <u>R10674PI</u> | 03/19/2021 | Second Update to Policies on the Enrollment of Opioid Treatment Programs (OTPs) | 01/29/2021 | 12113 |
| <u>R10611PI</u> | 03/19/2021 | Completion of Removal/Moving of Instructions from Chapter 15 of Publication (Pub.) 100-08 to Chapter 10 of Pub. 100-08 | 11/19/2020 | 11917 |
| <u>R10560PI</u> | 01/20/2021 | Second Update to Policies on the Enrollment of Opioid Treatment Programs (OTPs)- Rescinded and replaced by transmittal 10674 | 01/29/2021 | 12113 |
| <u>R10524PI</u> | 12/17/2020 | Chapter 15 of Publication (Pub.) 100-08 Manual Redesign – Additional Release of Chapter 10 | 11/13/2020 | 11700 |
| <u>R10467PI</u> | 11/13/2020 | Update to Chapter 10 of Publication (Pub.) 100-08 - Enrollment Policies for Home Infusion Therapy (HIT) Suppliers | 11/01/2020 | 11954 |
| <u>R10481PI</u> | 11/18/2020 | Update to Policies on the Enrollment of Opioid Treatment Programs (OTPs) | 11/20/2020 | 12058 |
| <u>R10434PI</u> | 10/30/2020 | Update to Chapter 10 of Publication (Pub.) 100-08 - Enrollment Policies for Home Infusion Therapy (HIT) Suppliers – | 11/01/2021 | 11954 |

| Rev # | Issue Date | Subject | Impl Date | CR# |
|-----------------|------------|---|------------|-------|
| | | Rescinded and Replaced by Transmittal 10467 | | |
| <u>R10355PI</u> | 09/18/2020 | Completion of Removal/Moving of Instructions from Chapter 15 of Publication (Pub.) 100-08 to Chapter 10 of Pub. 100-08- Rescinded and replaced by transmittal 10611 | 11/19/2020 | 11917 |
| <u>R10353PI</u> | 09/11/2020 | Chapter 15 of Publication (Pub.) 100-08 Manual Redesign – Additional Release of Chapter 10 of Pub. 100-08, Modification of the Timeliness Standards- Rescinded and Replaced by Transmittal 10727 | 02/01/2021 | 11865 |
| <u>R10345PI</u> | 09/11/2020 | Chapter 15 of Publication (Pub.) 100-08 Manual Redesign – Additional Release of Chapter 10- Rescinded and replaced by transmittal 10524 | 11/13/2020 | 11700 |
| <u>R10239PI</u> | 07/28/2020 | Implementation of Provider Enrollment Provisions in CMS-6058-FC – Phase 1 – Continued Removal/Moving of Instructions from Chapter 15 of Publication (Pub.) 100-08 to Chapter 10 of Pub. 100-08- Rescinded and replaced by transmittal 10723 | 08/10/2020 | 11551 |
| <u>R10228PI</u> | 07/27/2020 | Updates to Chapters 1, 2, 3, 4, 5, 6, 7, 8, 10, 11, and Exhibits of Publication (Pub.) 100-08 | 08/27/2020 | 11884 |
| | 07/10/2020 | Moving Chapter 15 (Medicare Enrollment) Manual Instructions in Publication (Pub.) 100-08 to Chapter 10 (Medicare Enrollment) | 06/16/2020 | 11546 |
| <u>R10146PI</u> | 05/22/2020 | Implementation of Provider Enrollment Provisions in CMS-6058-FC – Phase 1 – Continued Removal/Moving of Instructions from Chapter 15 of Publication (Pub.) 100-08 to Chapter 10 of Pub. 100-08– Rescinded and replaced by Transmittal 10239 | 07/24/2020 | 11551 |
| <u>R10182PI</u> | 05/15/2020 | Update to Chapter 10 of Publication (Pub.) 100-08 - Model Letter Templates | 09/16/2020 | 11375 |
| <u>R10138PI</u> | 06/15/2020 | Moving Chapter 15 (Medicare Enrollment) Manual Instructions in Publication (Pub.) 100-08 to Chapter 10 (Medicare Enrollment)- Rescinded and replaced by Transmittal 10219 | 06/16/2020 | 11546 |

| Rev # | Issue Date | Subject | Impl Date | CR# |
|---------------|-------------------|--|------------------|------------|
| <u>R434PI</u> | 09/14/2012 | Removal of Remaining Material from Chapter 10 of the Program Integrity Manual (PIM) | 10/16/2012 | 8026 |
| <u>R416PI</u> | 04/13/2012 | General Update to Chapter 15 of the Program Integrity Manual (PIM) –Part III | 02/27/2012 | 7698 |
| <u>R405PI</u> | 01/26/2012 | General Update to Chapter 15 of the Program Integrity Manual (PIM) –Part III – Rescinded and replaced by Transmittal 416 | 02/27/2012 | 7698 |
| <u>R386PI</u> | 09/01/2011 | Ordering/Referring Providers Who Are Not Enrolled in Medicare | 04/19/2010 | 6696 |
| <u>R363PI</u> | 01/14/2011 | Clarification for Part A Contractors Including Audit and Claims Intermediaries Notifying Each Other via E-mail Upon Processing of the Initial Enrollment Application, Change of Information, Voluntary Termination, or Any Other CMS-855 Transaction | 02/15/2011 | 7221 |
| <u>R356PI</u> | 09/24/2010 | Manual Redesign | 10/26/2010 | 7083 |
| <u>R354PI</u> | 08/27/2010 | Manual Redesign | 09/28/2010 | 7016 |
| <u>R347PI</u> | 07/15/2010 | Chapter 10 Manual Redesign - Initial release of Chapter 15 | 07/30/2010 | 6938 |
| <u>R344PI</u> | 06/18/2010 | Chapter 10 Manual Redesign - Initial release of Chapter 15 - Rescinded and replaced by Transmittal 347 | 07/05/2011 | 6938 |
| <u>R339PI</u> | 05/21/2010 | Cardiac Rehabilitation and Intensive Cardiac Rehabilitation | 10/04/2010 | 6850 |
| <u>R334PI</u> | 04/23/2010 | Update to Site Verification Process | 05/24/2010 | 6895 |
| <u>R332PI</u> | 03/26/2010 | Reporting Changes in Surety Bonds | 06/28/2010 | 6854 |
| <u>R329PI</u> | 03/19/2010 | Change in Provider Enrollment Timeliness Standards for Certain Paper Applications | 06/21/2010 | 6807 |
| <u>R328PI</u> | 03/19/2010 | Ordering/Referring Providers Who Are Not Enrolled in Medicare – Rescinded and replaced by Transmittal 386 | 04/19/2010 | 6696 |
| <u>R326PI</u> | 03/12/2010 | Revision of the Internet Only Manual to Remove References to “Purchased Diagnostic Test” and Replace With Language Consistent With the Anti-Markup Rule | 06/14/2010 | 6627 |
| <u>R324PI</u> | 02/05/2010 | Revisions to Model Approval Letters | 03/08/2010 | 6780 |
| <u>R323PI</u> | 01/29/2010 | Verification of Legal Status | 03/29/2010 | 6748 |

| Rev # | Issue Date | Subject | Impl Date | CR# |
|---------------|-------------------|---|------------------|------------|
| <u>R322PI</u> | 01/15/2010 | Durable Medical Equipment (DME MAC) and the National Supplier Clearinghouse (NSC MAC) Procedures for Third Party Notification of Deceased Durable Medical Equipment, Prosthetic, Orthotic and Supplies (DMEPOS) Supplier Associates | 7/06/2010 | 6714 |
| <u>R321PI</u> | 12/30/2009 | Verification of Legal Status Rescinded and replaced by Transmittal 323 | 03/29/2010 | 6748 |
| <u>R320PI</u> | 12/23/2009 | Provider Enrollment Revisions | 01/25/2010 | 6645 |
| <u>R318PI</u> | 12/18/2009 | Implementation of Home Health Agency Program Safeguard Provisions - Rescinded | 01/01/2010 | 6750 |
| <u>R316PI</u> | 12/04/2009 | Administrative Appeals Process for Provider Enrollment | 01/04/2010 | 6487 |
| <u>R315PI</u> | 12/04/2009 | Provider Enrollment and Veteran's Administration (VA) Hospitals | 03/08/2010 | 6735 |
| <u>R314PI</u> | 11/27/2009 | Clarification of Deactivation Instructions | 12/28/2009 | 6734 |
| <u>R312PI</u> | 11/20/2009 | Home Health Agency (HHA) Capitalization Requirements | 12/21/2009 | 6732 |
| <u>R307PI</u> | 10/23/2009 | Establishing New Practice Locations in a Different State | 01/25/2010 | 6649 |
| <u>R306PI</u> | 10/02/2009 | Site Verifications | 11/02/2009 | 6639 |
| <u>R304PI</u> | 09/25/2009 | Inter-Contractor Communication and Provider Enrollment Revocations | 10/26/2009 | 6642 |
| <u>R300PI</u> | 09/01/2009 | Compliance Standards for Consignment Closets and Stock and Bill Arrangements - Rescinded | 03/01/2010 | 6528 |
| <u>R299PI</u> | 08/28/2009 | Updates to Model Rejection, Returned Application, Revalidation, Approval, Denial/Revocation Letters and Identity Theft Prevention Letter | 09/28/2009 | 6527 |
| <u>R297PI</u> | 08/07/2009 | Compliance Standards for Consignment Closets and Stock and Bill Arrangements - Rescinded and replaced by Transmittal 300 | 09/08/2009 | 6528 |
| <u>R296PI</u> | 07/10/2009 | Provider Enrollment Verification Activities | 08/10/2009 | 6499 |
| <u>R295PI</u> | 06/29/2009 | Revision to Certain Instructions Related to Provider Enrollment Deactivations and Revocations | 07/27/2009 | 6491 |
| <u>R291PI</u> | 06/12/2009 | Reassignment and Ambulatory Surgical Centers (ASCs) | 10/05/2009 | 6470 |

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|---------------|-------------------|--|------------------|------------|
| <u>R289PI</u> | 04/15/2009 | Incorporation of Physician Fee Schedule Regulatory Changes | 04/01/2009 | 6310 |
| <u>R288PI</u> | 04/02/2009 | Incorporation of Physician Fee Schedule Regulatory Changes - Rescinded and replaced by Transmittal 289 | 04/01/2009 | 6310 |
| <u>R287PI</u> | 03/27/2009 | Surety Bonds for Suppliers of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) | 04/06/2009 | 6392 |
| <u>286PI</u> | 03/13/2009 | Incorporation of Physician Fee Schedule Regulatory Changes – Rescinded and replaced by Transmittal 288 | 04/01/2009 | 6310 |
| <u>R284PI</u> | 02/20/2009 | Model Letter Updates | 03/20/2009 | 6244 |
| <u>R280PI</u> | 12/31/2008 | Incorporation of Recent Regulatory Revisions Pertinent to Suppliers of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) | 02/02/2009 | 6282 |
| <u>R277PI</u> | 12/19/2008 | Additional Provider Enrollment Verification and Program Integrity Activities | 01/20/2009 | 6097 |
| <u>R276PI</u> | 12/19/2008 | Deceased Individuals and the Provider Enrollment Process | 01/20/2009 | 6194 |
| <u>R275PI</u> | 12/12/2008 | Administrative Appeals for Provider Enrollment | 01/12/2009 | 6248 |
| <u>R272PI</u> | 11/07/2008 | Clarification of Provider Enrollment Procedures Involving Certified Suppliers and Providers | 12/08/2008 | 6151 |
| <u>R271PI</u> | 10/24/2008 | Instructions for the Implementation of the Internet-Based Provider Enrollment, Chain and Ownership System (PECOS) | 11/24/2008 | 6231 |
| <u>R269PI</u> | 09/19/2008 | Incorporation of Recent Regulatory Revisions into Chapter 10 of the Program Integrity Manual | 10/20/2008 | 6178 |
| <u>R266PI</u> | 09/05/2008 | Model Letters | 10/06/2008 | 6051 |
| <u>R261PI</u> | 06/27/2008 | Update to Section 12 of Chapter 10 of the Program Integrity Manual | 07/28/2008 | 6071 |
| <u>R260PI</u> | 06/20/2008 | Clarification of Chapter 10 | 07/22/2008 | 6065 |
| <u>R251PI</u> | 04/11/2008 | Administrative Appeals for Provider Enrollment | 05/12/2008 | 5826 |
| <u>R246PI</u> | 03/14/2008 | Clarification of Items in Chapter 10 | 04/14/2008 | 5952 |
| <u>R236PI</u> | 02/01/2008 | Update to Chapter 10 | 03/03/2008 | 5892 |

| Rev # | Issue Date | Subject | Impl Date | CR# |
|---------------|-------------------|---|------------------|------------|
| <u>R234PI</u> | 01/18/2008 | Revision to Instructions Relating to Compliance Standards for Independent Diagnostic Testing Facilities (IDTFs) | 04/22/2008 | 5856 |
| <u>R233PI</u> | 01/18/2008 | Update to Chapter 10 | 02/20/2008 | 5862 |
| <u>R232PI</u> | 01/04/2008 | Clarification of Standards for Processing CMS-855 Enrollment Applications | 02/04/2008 | 5854 |
| <u>R230PI</u> | 12/14/2007 | Update to Chapter 10 | 01/07/2008 | 5802 |
| <u>R227PI</u> | 11/02/2007 | Update to Requirement to Submit National Provider Identifier (NPI) Notification | 01/07/2008 | 5795 |
| <u>R221PI</u> | 09/06/2007 | Administrative Appeals for Provider Enrollment | 10/01/2007 | 5467 |
| <u>R219PI</u> | 08/17/2007 | Nurse Practitioner (NP) Services and Clinical Nurse Specialist (CNS) Services | 11/19/2007 | 5639 |
| <u>R218PI</u> | 08/10/2007 | Provider Enrollment Manual Update | 10/01/2007 | 5671 |
| <u>R217PI</u> | 07/13/2007 | Provider Enrollment Fraud Detection Program for High Risk Areas | 08/13/2007 | 5633 |
| <u>R216PI</u> | 07/13/2007 | Implementation of New Compliance Standards for Independent Diagnostic Testing Facilities (IDTFs) | 10/01/2007 | 5672 |
| <u>R214PI</u> | 06/29/2007 | Clarification of Provider Enrollment Revocations | 07/30/2007 | 5504 |
| <u>R212PI</u> | 06/29/2007 | Administrative Appeals for Provider Enrollment - Replaced by Transmittal 221 | 10/01/2007 | 5467 |
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