

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 765	Date: January 8, 2018
	Change Request 10356

SUBJECT: Medicare Diabetes Prevention Program (MDPP) Enrollment Process

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to outline the process by which MDPP Suppliers enroll into Medicare -- including how to screen both MDPP suppliers and coaches whose identifying information will be submitted on the new MDPP supplier enrollment application, CMS-20134.

EFFECTIVE DATE: January 1, 2018

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

IMPLEMENTATION DATE: January 19, 2018 - Or as soon as possible prior to this date.

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R=REVISED, N=NEW, D=DELETED-Only One Per Row.

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	15/TOC
R	15/15.1/15.1.1/Definitions
R	15/15.1/15.1.2/Medicare Enrollment Application
R	15/15.1/15.1.3/Medicare Contractor Duties
R	15/15.2/Provider and Supplier Business Structures
R	15/15.3/National Provider Identifier (NPI)
R	15/15.3/15.3.1/NPI-Legacy Combinations
N	15/15.4/15.4.6/15.4.6.4/Medicare Diabetes Prevention Program (MDPP) Suppliers
R	15/15.4/15.4.8/Suppliers Not Eligible to Participate
R	15/15.5/Sections of the Forms CMS-855A, CMS-855B, CMS-855I, and CMS - 20134
R	15/15.5/15.5.1/Basic Information (Section 1 of the Form CMS-855 and CMS-20134)
R	15/15.5/15.5.2/Identifying Information (Section 2 of the Form CMS-855 and CMS-20134)
R	15/15.5/15.5.2/15.5.2.1/Licenses, Certifications, and Recognition
R	15/15.5/15.5.2/15.5.2.2/Correspondence Address and E-mail Addresses
N	15/15.5/15.5.2/15.5.2.7/Section 2 of the Form CMS-20134
R	15/15.5/15.5.3/Final Adverse Actions
R	15/15.5/15.5.4/Practice and Administrative Location Information
N	15/15.5/15.5.4./15.5.4.4/Section 4 of the Form CMS-20134
R	15/15.5/15.5.5/Owning and Managing Organizations
R	15/15.5/15.5.6/Owning and Managing Individuals
R	15/15.5/15.5.6/15.5.6.1/Tax Identification Numbers (TINs) of Owning and Managing Individuals and Organizations
R	15/15.5/15.5.8/Billing Agencies
N	15/15.5/15.5.9/Special Requirements for MDPP Suppliers: Section 7 of Form CMS-20134
R	15/15.5/15.5.13/Contact Persons
R	15/15.5/15.5.14/Certification Statement Signature Requirements
R	15/15.5/15.5.14/15.5.14.3/Form CMS-855A, Form CMS-855B, Form CMS-855S, and CMS-20134 Signatories
R	15/15.5/15.5.14/15.5.14.3/15.5.14.3.1/Authorized Officials
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R	15/15.5/15.5.15/15.5.15.2/Form CMS-855A, Form CMS-855B, and Form CMS-20134 Signatories
N	15/15.5/15.5.16/Supporting Documents
N	15/15.5/15.5.17/Supporting Documents for MDPP Suppliers - Recognition Status
R	15/15.6/Timeliness and Accuracy Standards
R	15/15.6/15.6.1/Standards for Initial and Revalidation Applications
R	15/15.6/15.6.1/15.6.1.1 /15.6.1.1.1/Form CMS-855 and Form CMS-20134 Applications That Require a Site Visit
R	15/15.6/15.6.1/15.6.1.1/15.6.1.1.2/Form CMS-855 and Form CMS-20134 Applications That Do Not Require a Site Visit
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R	15/15.6/15.6.1/15.6.1.3/Web-Based Applications - Timeliness
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N	15/15.7/15.7.5/15.7.5.2/Special Procedures for MDPP Suppliers
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R	15/15.10/15.10.1/15.10.1.1/Changes of Information and Complete Form CMS-855 and Form CMS-20134 Applications
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R	15/15.14/15.14.2/Contractor Communications
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N	15/15.17/15.17.2/Effective Date for MDPP Suppliers
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R	15/15.22/15.22.2/Provider Enrollment Inquiries
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R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
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R	15/15.24/15.24.5/15.24.5.7/Model Return Revalidation Letter
R	15/15.24/15.24.7/15.24.7.1/Model Approval Letter
R	15/15.24/15.24.8/Denial Letter Guidance
N	15/15.24/15.24.8/15.24.8.7/Denial Example #6 – MDPP Standards Not Met – Ineligible coach
R	15/15.24/15.24.9/Revocation Letter Guidance
N	15/15.24/15.24.9/15.24.9.5/Revocation Example #3 – MDPP supplier Use of an Ineligible Coach
R	15/15.24/15.24.14/Model Documentation Request Letter
R	15/15.27/15.27.1/15.27.1.2/15.27.1.2.1/Reactivations - Deactivation for Reasons Other Than Non-Submission of a Claim
R	15/15.27/15.27.1/15.27.1.2/15.27.1.2.2/Reactivations - Deactivation for Non-Submission of a Claim
R	15/15.27/15.27.1/15.27.1.2/15.27.1.2.3/Reactivations – Miscellaneous Policies
R	15/15.27/15.27.2/Revocations
R	15/15.27/15.27.3/Other Identified Revocations
R	15/15.27/15.27.4/External Reporting Requirements

III. FUNDING:

For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

**Business Requirements
Manual Instruction**

Attachment - Business Requirements

Pub. 100-08	Transmittal: 765	Date: January 8, 2018	Change Request: 10356
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SUBJECT: Medicare Diabetes Prevention Program (MDPP) Enrollment Process

EFFECTIVE DATE: January 1, 2018

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

IMPLEMENTATION DATE: January 19, 2018 - Or as soon as possible prior to this date.

I. GENERAL INFORMATION

A. Background: 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 with an indication of pre-diabetes, as defined for this model. The primary goal of the intervention is lowering the progression to type two (2) diabetes, measured using a proxy of at least five percent average weight loss among participants.

The Centers for Medicare & Medicaid Services (CMS) first tested the DPP program in the Medicare population through a Round One Health Care Innovation Award. In March 2016, Health and Human Services (HHS) announced that CMS 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 the expansion requirements of Section 1115A of the Social Security Act (the Act) making DPP the first ever preventive service model certified for expansion from the CMS Innovation Center.

On November 4, 2016, CMS released the final rule in the 2017 Physician Fee Schedule (PFS), which established the start of the expanded DPP model into Medicare (referred to as MDPP) starting on January 1, 2018. The 2017 PFS rule finalizes aspects of the expansion that enabled organizations, including those new to Medicare, to prepare for enrollment into Medicare as MDPP suppliers. Namely, the regulation established a new supplier type, MDPP suppliers, specific for furnishing the MDPP model. We anticipate that the 2018 PFS will propose remaining policies related to payment, virtual providers, and other program integrity safeguards that will enable MDPP suppliers to enroll.

Together, the Fiscal Year (FY) 2017 PFS and the FY 2018 PFS will establish components of the MDPP program that permit eligible organizations to enroll into Medicare.

The target implementation date for this CR is January 2, 2018 to enable MDPP suppliers to enroll into Medicare.

Details on MDPP suppliers are as follows:

Enrollment eligibility

Entities may enroll as an MDPP supplier, provided that it has preliminary or full recognition as determined by the Center for Disease Control and Prevention's (CDC) Diabetes Prevention Recognition Program (DPRP), has obtained and maintained valid tax identification number and National Provider Identifier at the organizational level, has passed application screening at a high categorical risk level per § 424.518(c) upon initial enrollment and at a moderate categorical risk level per § 424.518(b) upon revalidation, and complies with the supplier standards.

Enrollment process

MDPP is an Additional Preventive Service and will be paid using the Part B Trust Fund. While Part B suppliers typically enroll into Medicare using CMS Form 855-B, for the purposes of the expanded model test, a new enrollment application form will be created specific to MDPP suppliers. While this form closely builds off the 855-B, it will remain distinct and the information collected will be specific to MDPP suppliers. The title of this form is Form CMS-20134. The document included in this CR is a draft, for illustrative purpose, and will have minor changes. We will upload the final form prior to issuing this CR.

NOTE: Because this is a non-855 form, many of the Pub. 100-08 manual sections that previously referenced the 855 forms generally required updates to include references to CMS-20134.

Effective Date of Billing Privileges

The effective date for Medicare billing privileges for MDPP suppliers is the later of --

- The date of filing of a Medicare enrollment application that was subsequently approved by a Medicare contractor;
- The date of filing of a corrective action plan that was subsequently approved by a Medicare contractor; or
- The date that the supplier first began furnishing services at a new administrative location that resulted in a new enrollment record or Provider Transaction Access Number.

However, though MDPP suppliers may submit their enrollment application on or after January 1, 2018, MDPP services will be proposed to become available on April 1, 2018. Thus, under no circumstances can the effective date for billing privileges be prior to April 1, 2018.

MDPP Supplier Standards

A MDPP supplier must meet and must certify in its enrollment application that it meets and will continue to meet a number of standards. The MACs will check many of these standards, but not all of them, upon enrollment. You can find the full list of finalized standards at 424.205(d). The standards that affect the MDPP supplier's enrollment process are as follows:

- The MDPP supplier must have and maintain MDPP preliminary recognition (which includes MDPP interim preliminary and CDC preliminary recognition), or full CDC DPRP recognition.
- The MDPP supplier must not currently have its billing privileges terminated or be excluded by a State Medicaid agency.
- 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 outlined in paragraph (e)(1) of this section. (for full details on what constitute an eligible coach, please see details below).
- The MDPP supplier must maintain at least one administrative location on an appropriate site. This site may not be a private residence. This location, and all administrative locations, must be reported on the enrollment application. An appropriate site would include all of the following characteristics: (i) 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. (ii) Open for business during stated operational hours. (iii) Employees, staff, or volunteers present during operational hours. (iv) Not be a private residence.
- The MDPP supplier must update its enrollment application within 30 days for any changes of ownership, changes to the coach roster, and final adverse action history, and report all other changes to CMS within 90 days.

Eligible Coaches

Some definitions related to coaches are as follows:

- **Coach** means an individual who furnishes MDPP services on behalf of an MDPP supplier as an employee, contractor, or volunteer.
- **Eligible coach** means an individual who CMS has screened and determined can provide MDPP services on behalf of an MDPP supplier based on the standard specified at 424.59(d)(3)(i).
- **Ineligible coach** means an individual whom CMS has screened and determined cannot provide MDPP services on behalf of an MDPP supplier based on the standard specified at 424.59(d)(3)(i).
- **Coach eligibility start date**, for a coach that CMS determines to be eligible, this refers to the start date the MDPP supplier submitted when it submitted the coach's information on its MDPP enrollment application.
- **Coach ineligibility end date**, for a coach that CMS determined to be eligible, this refers to the end date that the MDPP supplier submitted when it submitted a change to its MDPP enrollment application that removed the coach's information (either due to coach ineligibility, because the coach was no longer working for the MDPP supplier, or because the supplier itself was revoked from or withdrew its Medicare enrollment).

MDPP supplier must submit coach information (date of birth, first and last name, social security number, and national provider identifier) on its enrollment application.

The MDPP supplier must not permit MDPP services to be furnished by or included on its roster any individual coach who meets any of the following:

- Currently has Medicare billing privileges revoked and a reenrollment bar has not yet expired.
- Currently has its Medicaid billing privileges terminated or is excluded by a State Medicaid agency.
- Is currently excluded from any other Federal health care program, as defined in § 1001.2 of this chapter, in accordance with section 1128, 1128A, 1156, 1842, 1862, 1867 or 1892 of the Act.
- Is currently 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.
- Has, in the previous 10 years, one of the following State or Federal felony convictions:
 1. 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.
 2. 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.
 3. Any felony that placed the Medicare or its beneficiaries at immediate risk, such as a malpractice suit that results in a conviction of criminal neglect or misconduct.
 4. Any felonies that would result in mandatory exclusion under section 1128(a) of the Act.

Once CMS determines that a coach does not meet the above-specified conditions, his or her eligibility start date becomes effective and remains effective until an MDPP supplier takes action that results in an eligibility end date. As outlined in the business requirements, the MACs are to screen the coaches for these ineligibility criteria with the resources that are available. Notably, MACs may be unable to determine some of these criteria (i.e., current Medicaid termination).

B. Policy: Section 1115A of the Act

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
10356.1	Contractors shall process all MDPP supplier enrollment applications, Form CMS-20134.		X							
10356.1.1	Contractors shall process section 1 of the Form CMS-20134 in accordance with section 15.5.1 in chapter 15 of Pub-100-08.		X							
10356.1.2	Contractors shall process section 2 of the Form CMS-20134 in accordance with sections 15.5.2, 15.5.2.7, and 15.5.6.1 in chapter 15 of Pub-100-08.		X							
10356.1.3	Contractors shall process section 3 of the Form CMS-20134 in accordance with sections 15.5.3, 15.7.5.2, and 15.5.17 in chapter 15 of Pub-100-08.		X							
10356.1.4	Contractors shall process section 4 of the Form CMS-20134 in accordance with sections 15.4 and 15.4.4 in chapter 15 of Pub-100-08.		X							
10356.1.5	Contractors shall process section 5 of the Form CMS-20134 in accordance with section 15.5.5 in chapter 15 of Pub-100-08.		X							
10356.1.6	Contractors shall process section 6 of the Form CMS-20134 in accordance with section 15.5.6 in chapter 15 of Pub-100-08.		X							
10356.1.6.1	Contractors shall initiate a fingerprint request for all individuals identified as being a 5% or greater		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	direct/indirect owner of an MDPP supplier initially enrolling.									
10356.1.7	Contractors shall process section 7 of the Form CMS-20134 in accordance with section 15.5.9 in chapter 15 of Pub-100-08.		X							
10356.1.8	Contractors shall process section 8 of the Form CMS-20134 in accordance with section 15.5.8 of chapter 15 in Pub-100-08.		X							
10356.1.9	Contractors shall process section 13 of the Form CMS-20134 in accordance with section 15.5.13 of chapter 15 in Pub-100-08.		X							
10356.1.10	Contractors shall process section 15 of the Form CMS-20134 in accordance with sections 15.5.14, 15.5.14.3, 15.5.14.3.1, 15.5.14.4, and 15.5.15.2 of chapter 15 in Pub-100-08.		X							
10356.1.11	Contractors shall process section 16 of the Form CMS-20134 in accordance with section 15.5.14.3.2 of chapter 15 in Pub-100-08.		X							
10356.1.12	Contractors shall process section 17 of the Form CMS-20134 in accordance with sections 15.5.16 and 15.5.17 of chapter 15 in Pub-100-08.		X							
10356.1.13	Contractors shall process any development requests in accordance with sections 15.7.1.5, 15.7.1.6, and 15.24.14 of chapter 15 in Pub-100-08.		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
10356.1.14	Contractors shall adhere to any processing alternatives to the Form CMS-20134 in accordance with section 15.7.1.3.5 of chapter 15 in Pub-100-08.		X							
10356.2	Contractors shall process changes of information to the Form CMS-20134 in accordance with sections 15.6.2, 15.7.7.1, 15.10.1, 15.10.1.1, 15.19.2.3 of chapter 15 in Pub-100-08.		X							
10356.3	Contractors shall screen MDPP suppliers upon initial enrollment as high categorical risk in accordance with section 15.19.2.1 of chapter 15 in Pub-100-08.		X							
10356.4	Contractors shall initiate site visits for one MDPP supplier administrative location in accordance with sections 15.6.1.1.1, 15.6.1.1.2, 15.6.1.3.1, 15.6.1.3.2, 15.19.2.2, and 15.20.1 of chapter 15 in Pub-100-08.		X							
10356.4.1	Contractors shall request national site visit contractor to conduct the site visit for the selected administrative location.		X							
10356.4.2	Contractors shall review the results of the site visit form to confirm that the MDPP supplier is in compliance with MDPP supplier standard requirements outlined in section 15.4.6.4 of chapter 15 in Pub-100-08.		X							
10356.5	Contractors shall process form CMS-20134 applications in accordance		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	with sections 15.6.1.3, 15.6.1.3.1, 15.6.2.1, 15.6.2.3, and 15.6.3 of chapter 15 in Pub-100-08.									
10356.6	Contractors shall refer to and implement directives in section 15.6.1.2, 15.6.1.4, 15.6.2.2, and 15.6.2.4 of chapter 15 in Pub-100-08 for questions related to accuracy.		X							
10356.7	Contractors shall process enrollment denials for MDPP suppliers in accordance with sections 15.8.4, 15.24.8, and 15.24.8.7 of chapter 15 in Pub-100-08.		X							
10356.8	Contractors shall process enrollment approvals for MDPP suppliers in accordance with sections 15.9.4 and 15.24.7.1 of chapter 15 in Pub-100-08.		X							
10356.9	Contractors shall revalidate MDPP suppliers every 5 years in accordance with section 15.19.2.1 of chapter 15 in Pub-100-08.		X							
10356.10	Contractors shall assign MDPP suppliers PTANS in accordance with section 15.14.8 of chapter 15 in Pub-100-08.		X							
10356.11	Contractors shall only assign an MDPP supplier a new PTAN when an MDPP supplier administrative location has a unique CDC organizational code-jurisdiction combination. Note: When an MDPP supplier is adding an administrative location that		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	has the same organization code to an existing enrollment, the contractor may issue a new PTAN if that location resides in a different state than the supplier's existing administrative locations.									
10356.12	Contractors shall process application fees for Form CMS-20134 applications in accordance with section 15.1.1 of chapter 15 in Pub-100-08.		X							
10356.13	Contractors shall process a revocation of an MDPP supplier's enrollment in accordance with sections 15.24.9, 15.27.3, 15.24.9.5, and 15.27.3 of chapter 15 in Pub-100-08.		X							
10356.14	Contractors shall revalidate MDPP suppliers' enrollment in accordance with sections 15.24.5, 15.24.5.3, 15.24.5.4, 15.24.5.7, 15.29, and 15.29.4 of chapter 15 in Pub-100-08.		X							
10356.15	Contractors shall reactivate an MDPP supplier's enrollment, when appropriate, in accordance with section 15.19.2.4, 15.27.1.2.1, and 15.27.1.2.2 of chapter 15 in Pub-100-08.		X							
10356.16	Contractors shall adhere to external reporting information on MDPP supplier enrollment as outlined in section 15.27.4 of chapter 15 in Pub-100-08.		X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): Arielle Zina, 650-773-8987 or arielle.zina@cms.hhs.gov

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

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

Medicare Program Integrity Manual

Chapter 15 - Medicare Enrollment

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15.5 – Sections of the Forms CMS-855A, CMS-855B, CMS-855I, *and CMS-20134*

15.5.1 – Basic Information (Section 1 of the Form CMS-855, *and CMS-20134*)

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15.17.2 - Effective Date for MDPP Suppliers

15.24.8.7 – Denial Example #6 – MDPP Supplier Standards Not Met – Ineligible Coach

15.24.9.5 – Revocation Example #3 – MDPP Supplier Use of an Ineligible Coach

15.1.1 – Definitions

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

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.

Administrative Location means a physical location associated with a Medicare Diabetes Prevention Program (MDPP) supplier's operations, from where coaches are dispatched or based, and where 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 receive a Medicare billing number and be granted Medicare billing privileges.

Authorized official means an appointed official (e.g., 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 100-04, chapter 1, section 30.2.4.)

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.

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 specified.

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 their 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 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.

Deny/Denial means the enrolling provider or supplier has been determined to be ineligible to receive Medicare billing privileges.

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 CMS-855 *or CMS-20134* enrollment application or the equivalent electronic enrollment process approved by the Office of Management and Budget (OMB).

Final adverse action means one or more of the following actions:

- (i) A Medicare-imposed revocation of any Medicare billing privileges;
- (ii) Suspension or revocation of a license to provide health care by any State licensing authority;
- (iii) Revocation or suspension by an accreditation organization;
- (iv) 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
- (v) An exclusion or debarment from participation in a Federal or State health care program.

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 that 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 (MIN) is the CMS Certification Number (CCN). For Part B suppliers other than suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS), the MIN is the Provider Identification Number (PIN). For DMEPOS suppliers, the MIN is the number issued to the supplier by the NSC. (Note that for Part B and DMEPOS suppliers, the Medicare Identification Number may sometimes be referred to as 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.

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.

Processed (application) - means that a provider or supplier's enrollment application was received by a Medicare Administrative Contractor (MAC) and the MAC has made a final determination on the application submission. Finalized outcomes include; rejected, approved, approval pending RO review, and denied. Regardless of whether or not an application is a part of a submission package or submitted alone each application is counted as a separate submission for the purpose of inventory and timeliness reporting.

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 Publication 100-04, chapter 1, sections 30.2 – 30.2.16.)

Receipt (application) - Regardless of whether or not an application is a part of a submission package or submitted alone each application is counted as a separate submission for the purpose of inventory and timeliness reporting.

Reject/Rejected means that the provider or supplier’s enrollment application was not approved due to incomplete information or that additional information or corrected information was not received from the provider or supplier in a timely manner.

Revoke/Revocation means that the provider 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.

15.1.2 – Medicare Enrollment Application

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

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-855I).

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

The five enrollment applications are distinguished as follows:

- CMS-855I - 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.)

- CMS-855R - 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.

- CMS-855B - 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.

- CMS-855A - This application should be completed by institutional providers (e.g., hospitals) that will furnish Medicare Part A services to beneficiaries.

- CMS-855S – 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.

- *CMS – 20134– This application should be completed by any supplier organizations that will furnish and bill Medicare Part B for the Medicare Diabetes Prevention Program services furnished to Medicare beneficiaries.*

A separate application must be submitted for each provider/supplier type.

When a prospective provider or supplier contacts the contractor to obtain a paper enrollment Form CMS-855, 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 (www.cms.hhs.gov/MedicareProviderSupEnroll).

- Any supporting documentation required for the applicant's provider/supplier type.

- Other required forms, including:

- The Electronic Funds Transfer Authorization Agreement (Form CMS-588) (Note: The NSC is only required to collect the Form CMS-588 with initial enrollment applications.)

- The Electronic Data Interchange agreement (Note: This does not apply to the NSC.)

- The Medicare Participating Physician or Supplier Agreement (Form CMS-460). 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 and CMS-855I.)

- The contractor's address so that the applicant knows where to return the completed application.

- If the applicant is a certified supplier or certified provider, the 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.) The notification can be given in any manner the contractor chooses.

15.1.3 – Medicare Contractor Duties

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

The contractor shall adhere to all of the instructions in this chapter 15 (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.

B. PECOS

The contractor shall:

- Process all enrollment actions (e.g., initials, changes, revalidations) 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
- 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 *or CMS-20134* applications and the appropriate entry of data into PECOS.

C. Validation and Processing

The contractor shall:

- Review the application to determine whether it is complete and that all information and supporting documentation required for the applicant's provider/supplier type has been submitted on and with the appropriate enrollment application. Unless stated otherwise in this chapter or in another CMS directive, the provider must complete all required data elements on the Form CMS-855 *or CMS-20134* via the application itself.
- Unless stated otherwise in this chapter or in another CMS directive, verify and validate all information collected on the enrollment application, provided that a data source is available.
- Coordinate with State survey/certification agencies and regional offices (ROs), as needed
- Collect and maintain the application's certification statement (in house) to verify and validate Electronic Funds Transfer (EFT) changes in accordance with the instructions in this chapter and all other CMS directives.
- Confirm 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.

D. Customer Service

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., emails, letters, telephone calls) within 30 business days of receipt.

15.2 – Provider and Supplier Business Structures

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

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. 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.

C. 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 section 6. 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.

D. 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.”

E. 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.

F. 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*.

G. 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, section 5 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 section 6 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.

15.3 – National Provider Identifier (NPI)

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

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 NPES 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

¹ 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).

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.

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).

Medicare Statutes, Regulations, Manuals

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.

² Clinical laboratory certification is handled by the Food and Drug Administration.

- 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.

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.

³ Religious non-medical health care institutions are handled differently.

⁴ 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.

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, and independent diagnostic testing facilities (IDTFs) and *Medicare Diabetes Prevention Program (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 Medicare Administrative Contractor (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.

15.3.1 – NPI-Legacy Combinations

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

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.

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.

⁷ There may be exceptions for emergency or very unusual situations.

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.

15.4.6.4 – Medicare Diabetes Prevention Program (MDPP) Suppliers (Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

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.*

Violations of such standards are determined as non-compliance, and the associated enrolment denial and revocation authorities would apply.

15.4.8 - Suppliers Not Eligible to Participate

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

Below is a list of individuals and entities that frequently attempt to enroll in Medicare, but are not eligible to do so. 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
- Licensed Alcoholic and Drug Counselor
- Licensed Massage Therapist
- Licensed Practical Nurse
- Licensed Professional Counselor
- Marriage Family Therapist
- Master of Social Work
- Mental Health Counselor
- National Certified Counselor
- Occupational Therapist Assistant
- Physical Therapist Assistant
- Registered Nurse
- Speech and Hearing Center
- Substance Abuse Facility

15.5 – Sections of the Forms CMS-855A, CMS-855B, CMS-855I *and CMS-20134*

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

A. Background

Sections 15.5.1 through 15.5.19.7 below discuss various data elements on the Form CMS-855A, Form CMS-855B, Form CMS-855I, *and Form CMS-20134*. Not every data element on the forms is discussed in these sections; only those elements that warrant additional instructions are mentioned. Nonetheless, the contractor shall – unless stated otherwise in this chapter or in another CMS directive - adhere to all instructions in this chapter 15 in terms of the collection, processing, and verification of all data elements on the Form CMS-855 applications, regardless of whether the data element in question is discussed in sections 15.5.1 through 15.5.19.7.

For purposes of these sections, and unless otherwise indicated, the term “approval” includes recommendations for approval.

B. Precedence of Sections 15.7 through 15.7.1.6.2

Though the contractor shall follow the instructions in sections 15.5.1 through 15.5.19.7, any specific processing or verification instructions in sections 15.5.7 through 15.7.1.6.2 shall – unless stated otherwise in this chapter or in another CMS directive - take precedence over those in sections 15.5.1 through 15.5.19.7.

See sections 15.7.1.3.1 and 15.7.1.3.2 for information regarding “processing alternatives.”

15.5.1 - Basic Information (Section 1 of the Form CMS-855 *and CMS-20134*)

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

Unless otherwise stated in this chapter or in another CMS directive, the provider may only check one reason for submittal. 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.

A provider shall enroll as an initial applicant if it is:

- Seeking to reestablish itself in the Medicare program after reinstatement from an exclusion or debarment or after the expiration of a reenrollment bar, or
- A hospital requesting enrollment via the Form CMS-855B to bill for practitioner services for hospital departments, outpatient locations and/or hospital clinics.
- *A hospital, clinic or other entity with an existing enrollment in Medicare requesting enrollment as an MDPP supplier via the Form CMS-20134 to bill for MDPP services.*

15.5.2 – Identifying Information (Section 2 of the Form CMS-855 *and Form CMS-20134*)

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

Unless specifically indicated otherwise, the instructions in sections 15.5.1 through 15.5.2.3 below apply to the Form CMS-855A, the Form CMS-855B, the Form CMS-855I, *and the Form CMS-20134*.

The instructions in section 15.5.2.4 apply only to the Form CMS-855A; the instructions in section 15.5.2.5 apply only to the Form CMS-855B; and the instructions in section 15.5.2.6 only apply to the Form CMS-855I; *and the instructions in section 15.5.2.6 only apply to the Form CMS-20134*.

15.5.2.1 – Licenses, Certifications, and Recognition

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

The extent to which the applicant must complete the licensure or certification information in section 2 of the Form CMS-855 depends upon the provider type involved. For instance, some states may require a particular provider to be “certified” but not “licensed,” or vice versa. *Additionally, applicants applying through the Form CMS-20134 are not required to have either a license or certification, but rather CDC recognition, described further in this section (see 15.5.2.1.C).*

The provisions in this section 15.5.2.1 are subject to the “processing alternatives” described in sections 15.7.1.3.1 through 15.7.1.3.2 *and 15.7.1.3.5* of this chapter.

A. Form CMS-855B and Form CMS-855I

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 section 4 of the Form CMS-855) will maintain a practice location.

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, though business licenses needed for the applicant to operate as a health care facility or practice must be submitted. 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 also adhere to the following:

- **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 ASCs and 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 the ASC or 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.

- **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.)

- **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.)

- **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.

- **Date of Enrollment** – 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.)

- **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 15.7.5.1 of this chapter for special instructions related to periodic license reviews and certain program integrity matters.

B. Form CMS-855A

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 section 2 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.

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

C. Form CMS-20134

To operate as an MDPP supplier, no licensure or certificate is needed. Rather, to be eligible to enroll as an MDPP supplier, the organization must have preliminary or full recognition from the Center for Disease Prevention and Control's (CDC) Diabetes Prevention Recognition Program (DPRP). For processing details, please refer to section 15.5.2.6.

15.5.2.2 – Correspondence Address and E-mail Addresses

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

A. Correspondence Address

The contractor may accept a particular correspondence address 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 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.

B. Correspondence Telephone Number

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.

C. Email Addresses

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

D. Contact Persons

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 email address) - the contractor has the discretion to use the contact persons listed in section 13 of the Form CMS-855 *or Form CMS-20134* for all written and oral communications (e.g., mail, email, 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 email address rather than the contact person's mailing or email address.

15.5.2.7 – Section 2 of the CMS-20134

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

A. Type of Supplier

The CMS-20134 application is specifically for 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.

B. 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 this section (section 2) 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.*

C. Correspondence Address and Email Address

Refer to processing steps outlined in 15.5.2.2.

15.5.3 – Final Adverse Actions

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

Unless stated otherwise, the instructions in this section 15.5.3 apply to the following sections of the Form CMS-855 *and Form CMS-20134*:

- Section 3
- Section 4A of the CMS-855I
- Section 5
- Section 6

A. 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 and date of the action, what court(s) and law enforcement authorities were involved, and how the adverse action was resolved. The documentation must be furnished regardless of whether the 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. It shall also ensure that the provider submits written proof of the reinstatement (e.g., reinstatement letter).
2. Revocation Reversals – Medicare revocations that were reversed on appeal need not be reported on the Form CMS-855 *or Form CMS-20134*.
3. 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. This includes Medicare revocations that: (1) were initiated by a different Medicare contractor in another contractor jurisdiction, and (2) involve a different provider or supplier type. Consider the following examples:

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 revoked, leaving 20 locations. Smith submits a Form CMS-855S application for a new location on Jones Street. The two revocations in 2010 must be reported on the Jones Street application. 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. Both the hospice and the hospital must report the revocation via a Form CMS-855A change request because the revocation occurred under the provider's LBN and TIN. Assume now that X seeks to enroll an ASC under X's LBN and TIN. The HHA revocation 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. Y now seeks to enroll an ASC in a fifth State. Y must disclose the DMEPOS revocation on the ASC's initial Form CMS-855, even though the revocation: (1) was done by a Medicare contractor other than that with which the ASC seeks enrollment, and (2) occurred in a state different from that in which the ASC is located.

Example (d) – Company Alpha is listed as an owner in section 5 of the Form CMS-855A. Alpha operates two health care providers – Y and Z - under its LBN and TIN. Y was subject to a General Services Administration debarment, which ended in 2009. The debarment would have to be reported in section 5, since it occurred under Z's LBN and TIN.

4. Timeframe – With the exception of the felony convictions identified in #1 under "Convictions" in section 3 of the Form CMS-855 *or Form CMS-20134*, all final adverse actions must be reported regardless of when they occurred.
5. Corporate Integrity Agreements (CIAs) – CIAs need not be disclosed on the Form CMS-855.

6. Evidence to Indicate Adverse Action – There may be instances where the provider or supplier states in section 3, 4A of the Form CMS-855I, 5, and/or 6 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 contact its CMS Provider Enrollment Business Function Lead (PEBFL) for guidance.

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.

B. 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 in this chapter; prior approval from CMS Central Office's provider enrollment unit (COPEU) is unnecessary. If any other final adverse action is listed, the contractor shall refer the matter to its PEBFL for review. When referring the action to its PEBFL (which shall be done via e-mail or fax), the contractor shall include the following information: (1) provider/supplier name and NPI; (2) version of the Form CMS-855 *or CMS-20134* involved; (3) reason for provider/supplier's submission of the application; (4) a summary of the adverse legal facts; and (5) whether the provider/supplier has previously disclosed this or any other final adverse action.

(If the contractor learns via any means other than the submission of a Form CMS-855 *or CMS-20134* (e.g., from law enforcement, notice from another contractor) that an enrolled provider or supplier has had any final adverse action (regardless of type) imposed against it, the contractor shall refer the matter to its PEBFL for guidance.)

C. Review of PECOS

If the contractor denies an application or revokes a provider based on a final adverse action, the contractor shall search PECOS (or, if the provider is not in PECOS, the contractor's internal system) to determine:

- Whether the person/entity with the adverse action has any other associations (e.g., is listed in PECOS as an owner of three Medicare-enrolled providers), or
- If the denial/revocation resulted from an adverse action imposed against an owner, managing employee, director, etc., of the provider, whether the person/entity in question has any other associations (e.g., a managing employee of the provider is identified as an owner of two other Medicare-enrolled HHAs).

If such an association is found and, per 42 CFR § 424.535, there are grounds for revoking the billing privileges of the other provider, the contractor shall initiate revocation proceedings with respect to the latter.

If the "other provider" is enrolled with a different contractor, the contractor shall notify the latter - via fax or e-mail – of the situation, at which time the latter shall take the revocation action. To illustrate, suppose John Smith attempted to enroll with Contractor X as a physician. Smith is currently listed as an owner of Jones Group Practice, which is enrolled with Contractor Y. Contractor X discovers that Smith was recently convicted of a felony. X therefore denies Smith's application. X must also notify Y of the felony conviction; Y shall then revoke Jones' billing privileges per 42 CFR § 424.535(a)(3).

D. 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-855 has had a final adverse action imposed against it, the contractor shall contact its PEBFL for guidance. *For any final adverse actions against individuals listed in section 7 of the Form CMS-20134, contractors shall refer to 15.5.9 where this process is outlined in detail.*

E. 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 Zone Program Integrity Contractor (ZPIC) 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.

15.5.4 – Practice *and Administrative* Location Information

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

Unless specifically indicated otherwise, the instructions in this section 15.5.4 apply to the Form CMS-855A, the Form CMS-855B, the Form CMS-855I, *and the CMS-20134*.

The instructions in section 15.5.4.1 apply only to the Form CMS-855A; the instructions in section 15.5.4.2 apply only to the Form CMS-855B; and the instructions in section 15.5.4.3 only apply to the Form CMS-855I; *and the instructions in section 15.5.4.4 only apply to the Form CMS-20134*.

A. Practice *and Administrative* Location Verification

The contractor shall verify that the practice *and administrative* locations listed on the application actually exist. If a particular location cannot at first be verified, the contractor shall request clarifying information; for instance, the contractor can request that the applicant furnish letterhead showing the appropriate address.)

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 15.7.3 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 MDPP suppliers enrolling through the Form CMS-20134, the entity must maintain a primary business telephone number listed under the name of the organization in public view. Public view could signify, for example, that the phone number is listed on a website, on flyers and materials. Additional information on this requirement and the need for a site visit is detailed in 15.6.1.1.3.*

Additionally, once the verification of practice *or administrative* locations is complete, the contractor need not verify the address via the Internet (for example, 411.com, USPS.com, etc.). Finalist (which is integrated

into PECOS) verifies the validity of an address with the United States Postal Service (USPS). Additional verification is only needed if Finalist cannot validate an actual address.

Also:

- If an individual practitioner or group practice: (1) is adding a practice location and (2) is normally required to complete a questionnaire in section 2 of the Form CMS-855I, Form CMS-855B, *or CMS-20134* specific to its supplier type (e.g., psychologists, physical therapists, *MDPP supplier*), the person or entity must submit an updated questionnaire to incorporate services rendered at the new location.
- Any provider submitting a Form CMS-855A, Form CMS-855B, Form CMS-855I, *or Form CMS-20134* application must submit the 9-digit ZIP Code for each practice *and administrative* 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). For suppliers paid via the Multi-Carrier System (MCS), the practice location name entered into PECOS shall be the legal business name.

B. 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 (section 4 of the Form CMS-855 *or CMS-20134*) or EFT information has changed. The provider should submit a Form CMS-855, *Form CMS-20134*, or Form 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-855, *or Form CMS-20134 as well as* Form CMS-588. The Durable Medical Equipment Medicare Administrative Contractors are 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-855 *or 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.

C. 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 *or 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.
- An updated section 4 that identifies the provider’s desired “special payments” address.

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

15.5.4.4 – Section 4 of the Form CMS-20134 (Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

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 15.1.1, 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 15.4.6.4.C.

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 15.6.1.1.3.

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 Administrative Locations

If a supplier is adding an administrative 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 3 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 location has the same CDC organizational code*

Consider the following examples:

1. The contractor's jurisdiction consists of States X, Y and Z. Jones Group Practice (JGP), Inc., is enrolled in State X with 3 administrative locations. It wants to add a fourth administrative location in State Y. The new administrative location will be under JGP, Inc., and will use the same organizational code for their recognition. JGP will not be establishing a separate corporation, LBN or TIN for the fourth location. Since there is no State or RO involvement with MDPP suppliers, all 3 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., organizational code, new managing employees). To the extent required, the contractor shall create a separate PECOS enrollment record for the State Y location. Given that the jurisdiction-organizational code combination remains the same, the contractor need not create a new PTAN for the State Y administrative location.

2. 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 administrative location will be under JGP, Inc., and will use the same organizational code for their recognition. JGP will not be establishing a separate corporation, LBN or TIN for the fourth location, however, it will have a different CDC organizational code than their other administrative locations. Because they are adding a location with a new organizational code, LGP can add the fourth location via an initial application. Given that this is a new organizational code-jurisdiction combination, the contractor shall create a separate PECOS enrollment record for the State Y location with a new PTAN.

3. The contractor's jurisdiction consists of States X, Y and Z. Jones Group Practice (JGP), Inc., is enrolled in State X with 3 administrative 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-20134.

4. *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.*

5. *The contractor's jurisdiction consists of States X, Y and Z. Jones Ambulatory Surgical Center (JASC), Inc., is enrolled in State X with 3 administrative locations. It wants to add a fourth administrative location in State Z under JASC, Inc. However, it has been determined that the new site includes a new organizational code. A separate, initial Form CMS-20134 is therefore necessary.*

15.5.5 – Owning and Managing Organizations

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

(This section only applies to section 5 of the Form CMS-855A, Form CMS-855B, *and Form CMS-20134*. It does not apply to the Form CMS-855I.)

All organizations that have any of the following must be listed in section 5A of the Form CMS-855 *or Form CMS-20134*:

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

The following illustrates the difference between direct and indirect ownership:

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

See the instructions for section 5 of the Form CMS-855 *or CMS-20134 on the enrollment application* for additional information on indirect ownership.

2. Mortgage or security interest

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

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

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

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

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

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

5. Managing control of the provider or supplier

A managing organization is one that exercises operational or managerial control over the provider, or conducts the day-to-day operations of the provider. The organization need not have an ownership interest in

the provider in order to qualify as a managing organization. For instance, the entity could be a management services organization under contract with the provider to furnish management services for one of the provider's practice locations.

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

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

In section 5(A)(2) of the Form CMS-855 *or the Form CMS-20134, as appropriate*, the provider must indicate the type(s) of organizational categories the reported entity falls into.

The following principles also apply with respect to section 5:

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

- The provider must submit an organizational structure diagram/flowchart identifying all of the entities listed in section 5 and their relationships with the provider and each other. (This applies to the Form CMS-855A, CMS-855B, CMS-855S, *and CMS-20134*.)
- If the provider is a skilled nursing facility (SNF), it must submit a diagram/flowchart identifying the organizational structures of all of its owners, including those that were not required to be listed in section 5 or 6. This must be submitted in addition to the diagram/flowchart in the previous bullet.

These diagrams/flowcharts must be submitted for initial enrollments, revalidations, Form CMS-855 reactivations, *Form CMS-20134 reactivations*, and upon any contractor request.

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

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

c. Section 2 - Any entity listed as the provider in section 2 of the Form CMS-855 *or CMS-20134* need not be reported in section 5A. The only exception involves governmental entities, which must be identified in section 5A even if they are already listed in section 2.

d. Governmental and Tribal Organization Letter - For governmental and tribal organizations, the letter referred to in the Form CMS-855 *or CMS-20134* instructions for section 5 must be signed by an appointed or elected official of the governmental or tribal entity who has the authority to legally and financially bind

the governmental or tribal entity to the laws, regulations, and program instructions of Medicare. This governmental or tribal official is not required to be an authorized official, or vice versa.

e. Non-Profit Organizations - Many non-profit organizations are charitable or religious in nature, and are operated and/or managed by a Board of Trustees or other governing body. The actual name of the Board of Trustees or other governing body must be listed in section 5A of the Form CMS-855 *or CMS-20134*. The provider must submit a copy of its 501(c)(3) approval notification for non-profit status. If it does not possess such documentation but nevertheless claims it is a non-profit entity, the provider may submit any other documentation that supports its claim (e.g., written documentation from the State).

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

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

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

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

i. 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 section 17 of the Form CMS-855 *or the Form 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 section 2B1 of the Form CMS-855 *or Form CMS-20134*.

15.5.6 – Owning and Managing Individuals

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

(This section applies to section 6 of the Form CMS-855A, the Form CMS-855B, the Form CMS-855I, *and the Form CMS-20134*.)

All individuals who have any of the following must be listed in section 6A:

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

(See section 15.5.5 of this chapter for more information on direct and indirect ownership, and on mortgage and security interests.)

3. Any general partnership interest in the provider, regardless of the percentage. This includes: (1) all interests in a non-limited partnership, and (2) all general partnership interests in a limited partnership.
4. For limited partnerships, any limited partnership interest that is 10 percent or greater.
5. Managing control of the provider. (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.)
6. Officers and directors/board members, 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 section 6 of the Form CMS-855 *or the Form 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 section 6. 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 section 6.

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 section 6. However, he/she may need to be listed as a managing employee in section 6.

In addition:

- 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 section 6 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 section 6 if it is completing the Form CMS-855A, the Form CMS-855B *or the Form 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 section 4C of the Form CMS-855I must be reported in section 6A. However, individuals who: (1) are employed by hospitals, health care facilities, or other organizations shown in section 4C (e.g., the chief executive officer of a hospital listed in section 4C), 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 section 6.

See section 15.5.6.1 of this chapter for special instructions regarding the reporting of tax identification numbers of owning and managing individuals.

15.5.6.1 – Tax Identification Numbers (TINs) of Owning and Managing Organizations and Individuals

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

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 sections 5 and 6, respectively, of the Form CMS-855 *and Form CMS-20134* 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 section 5 or 6, the contractor shall follow normal development procedures for requesting the TIN. In doing so, if the contractor learns or determines that the TIN was not furnished because the entity or person in question is foreign, the contractor shall take the following steps:

- a. 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.)
 - (1) If the provider fails to respond to the contractor's inquiry within 30 days, the contractor shall follow the instructions in (c) below.
 - (2) 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.
 - (3) 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. If the provider timely submits the explanation in (a)(3) 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. If the provider fails to timely respond to the contractor's inquiry in (a) or fails to timely furnish the TIN/ITIN in (a)(2), 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 15.7.3 of this chapter.

For purposes of this section 15.5.6.1 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 section 5 or 6.

15.5.8 – Billing Agencies

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

(Unless otherwise stated, this section applies to the Form CMS-855A, the Form CMS-855B, the Form CMS-855I, *and the Form CMS-20134*.)

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 section 8 of the Form CMS-855 *or Form 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 section 4 of the provider's Form CMS-855 *or Form 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.

If the chain organization listed in section 7 of the Form CMS-855A also serves as the provider's billing agent, the chain must be listed in section 8 as well.

For further information on billing agencies, see CMS Publication 100-04, chapter 1, section 30.2.4.

15.5.9 – Special Requirements for MDPP Suppliers: Section 7 of Form CMS-20134

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

A. 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 section 7 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

B. Coach Eligibility and Screening

As indicated Section 15.4.6.4, 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 Section 7 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.

C.. 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 section 7 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 Section 7 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.

D. 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 section 7 of the Form CMS-20134 to remove the ineligible coach. No further documentation is necessary.

E. 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 Section 7 of the Form CMS-20134 to provide MDPP services in violation of the CAP.

Further details are outlined in 15.27.3.C.

15.5.13 – Contact Persons

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

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 email) - the contractor has the discretion to use the contact persons listed in section 13 of the Form CMS-855 *or CMS-20134* for all written and oral communications (e.g., mail, email, 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 email address rather than the contact person's mailing or email address.

The provider may have as many contact persons as it wishes. 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, email, or fax. Currently there is no option on the CMS-855 *or 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-855 *or CMS-20134* form.

- If the contractor discovers that a particular contact person qualifies as an owning or managing individual, the contractor shall develop to the provider to determine if the person should be listed in section 6 of the application.
- 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.

15.5.14 – Certification Statement Signature Requirements

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

Unless otherwise specified, the instructions in sections 15.5.14 through 15.5.14.5 apply to: (1) signatures on the paper Form CMS-855 *or 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.

15.5.14.3 - Form CMS-855A, Form CMS-855B, *and Form CMS-20134* and Form CMS-855S Signatories

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

For Form CMS-855A, CMS-855B, CMS-855S, *and CMS-20134* initial applications, the certification statement must be signed and dated by an authorized official of the provider or supplier. (See section 15.1.1 and 15.5.14.3.1 of this chapter for a definition of "authorized official.").

For Form CMS-855A, CMS-855B, CMS-855S, *and 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.

15.5.14.3.1 - Authorized Officials

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

(Unless indicated otherwise below or in another CMS directive, the instructions in this section apply to (1) signatures on the paper Form CMS-855 *or Form CMS-20134*, (2) signatures on the certification statement for Internet-based Provider Enrollment, Chain and Ownership System (PECOS) applications, and (3) electronic signatures. (NOTE: This section only applies to the Form CMS-855A, the Form CMS-855B, *and the Form CMS-20134*.)

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.

If an authorized official is listed as a "Contracted Managing Employee" in section 6 of the Form CMS-855 *or Form CMS-20134* and does not qualify as an authorized official under some other category in section 6, 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 section 6 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.

In addition:

1. 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.
2. 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.
3. 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) section 6 of the Form CMS-855 *or 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.
4. Effective Date - The effective date in the Provider Enrollment, Chain and Ownership System for section 15 of the Form CMS-855 *or Form CMS-20134* should be the date of signature.
5. 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.
6. 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.
7. 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 Business Function Lead (BFL) for further clarification.

15.5.14.3.2 – Delegated Officials

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

A delegated official is an individual to whom an authorized official listed in section 15 of the Form CMS-855 *or 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 contractor shall note the following about delegated officials:

1. Authority - 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.
2. Section 6 – Section 6 of the Form CMS-855 *and CMS-20134* must be completed for all delegated officials.
3. Managing Employees - For purposes of section 16 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 section 6 of the Form CMS-855, Smith would have to be listed in that section. Yet under the section 16 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 section 16 of the Form CMS-855 *or CMS-20134*.
4. 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.
5. 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.

6. Effective Date - The effective date in PECOS for section 16 of the Form CMS-855 *or Form CMS-20134* should be the date of signature.

7. 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.

8. Deletion - 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.

9. 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.

10. 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) section 6 of the Form CMS-855 *or 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.)

11. Signature on Paper Application - If the provider submits a paper Form CMS-855 *or Form CMS-20134* change request, the contractor may accept the signature of a delegated official in Section 15 or 16 of the Form CMS-855, *or Form CMS-20134, as appropriate.*

15.5.14.4 – Submission of Paper and Internet-based PECOS Certification Statements *(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)*

A. Paper Submissions

A signed certification statement shall accompany the paper CMS-855 application *and 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) 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); (e) for paper Form CMS-855I and Form CMS-855O submissions, someone other than the physician or non-physician practitioner signed the form, except as noted in section 15.5.14.1; or (f) missing certification statements. 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 use the development date that the 30-day clock expires as the date of signature. Once the above step is complete, the contractor shall: (1) enter the date of signature in the "Certification Date" box in the logging & tracking (L & T) record, and (2) change the L & T status to "In Review."
- The certification statement may be returned via scanned email, fax or mail to the contractor (as long as an original certification statement signature exist on file).
- 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 initial paper applications (as the term “initial” is defined in section 15.6.1 of this chapter), it is only necessary that the dated signature of at least one of the provider’s authorized 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 15.6.2 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 sections 15.5.14.3.1 and 15.5.14.3.2 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.

B. 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 may do so by email, fax or mail (as long as an original certification statement signature exist on file). Unless stated otherwise in this chapter or in another CMS directive:

- The contractor shall not begin processing the application prior to its receipt of the certification statement.
- The provider must submit the paper certification statement within 20 calendar days of the date on which it submitted its Internet-based PECOS application. (This applies to all Form CMS-855 *and Form CMS-20134* Internet-based PECOS submissions, regardless of the type of transaction involved and applications where multiple signatures are required but not all have been submitted).
- If the contractor does not receive the certification statement in its mailroom (or via email/fax or through e-signature) within the 20-day period, the contractor shall reject the L&T (unless another CMS directive states otherwise). The contractor is not required to develop (This applies to revalidation and non-revalidation submissions).
- 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) 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. 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 initial Internet-based PECOS applications (as the term “initial” is defined in section 15.6.1 of this chapter), it is only necessary that the dated signature of at least one of the provider’s authorized officials be on the certification statement that must be sent in within 20 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 15.6.2 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 sections 15.5.14.3.1 and 15.5.14.3.2 of this chapter.
- If the application is submitted via Internet-based PECOS and the provider wishes to submit a paper CMS-855 *or CMS-20134* certification statement (downloaded from www.cms.gov), it should write the tracking ID on the top of the certification statement. If the provider does not list the tracking ID number on the signature page, but the contractor is able to identify which application the signature belongs to, development is not required. If the contractor is not able to identify the application through research or development due to missing contact information, the contractor shall return the signature page to the return address on the incoming envelope.
- 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.
- For internet-based PECOS submissions, if the provider mails in their signed certification statement but fails to electronically submit their web application, the MAC shall contact the provider and request they fully submit the application in PECOS. The receipt date of application shall be the date the application and all required signatures have been received.

15.5.15.2 – Form CMS-855A, Form CMS-855B, and Form CMS-20134 Signatories
(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

For Form CMS-855A, CMS-855B, *and CMS-20134* initial applications, the certification statement must be signed and dated by an authorized official of the provider. (See section 15.1.1 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. Section 6 of the Form CMS-855 *or Form CMS-20134* must be completed for each authorized official.

If an authorized official is listed as a “Contracted Managing Employee” in section 6 of the Form CMS-855 *or CMS-20134* and does not qualify as an authorized official under some other category in section 6, 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 section 6 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:

2. Original Signatures - For non-electronic signatures, the signature of an authorized official must be original. Faxed, stamped, or photocopied signatures cannot be accepted.
3. 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.

3. 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.
4. 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) section 6 of the Form CMS-855 *or 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.
5. Effective Date - The effective date in the Provider Enrollment, Chain and Ownership System for section 15 of the Form CMS-855 *or Form CMS-20134* should be the date of signature.
6. 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.
7. 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.
8. 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.

15.5.16 – Supporting Documents

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

Documentation of the provider/supplier's TIN is required with the CMS-855 in the following scenarios; initial enrollment, the addition of an EIN to a sole proprietor's enrollment record, a change of legal business name, and in any instance the contractor identifies a discrepancy between an application and/or CMS-588 EFT submission and the provider/supplier's enrollment record. The contractor does not need to develop otherwise.

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.

15.5.17 – Supporting Documents for MDPP Suppliers - Recognition Status

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

In addition to the information reported in Section 2 of the Form CMS-20134, MDPP suppliers must also submit any reporting documents as required, see 15.5.16 and Section 17 of the Form CMS-20134 for more information, as well as documentation to verify the organization's recognition status.

As outlined in 15.4.6.4, MDPP suppliers must have MDPP Preliminary recognition or full recognition, as determined by CMS.

A. Supporting Documents for MDPP Preliminary recognition

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 Section 2 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.*

B. 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 section 2 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 Section 2 of the Form CMS-20134*

15.6 - Timeliness and Accuracy Standards

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

Sections 15.6.1 through 15.6.3 of this chapter address the timeliness and accuracy standards applicable to the processing of Form CMS-855 *or Form CMS-20134* applications. Even though the provisions of 42 CFR §405.818 contain processing timeframes that differ than those in sections 15.6.1 through 15.6.3, the contractor shall adhere to the standards specified in sections 15.6.1 through 15.6.3.

The processing of an application generally includes, but is not limited to, the following activities:

- Receipt of the application in the contractor’s mailroom and forwarding it to the appropriate office for review.
- Prescreening the application.
- Creating a logging and tracking (L & T) record and an enrollment record in the Provider Enrollment, Chain and Ownership System (PECOS).
- Ensuring that the information on the application is verified.
- Requesting and receiving clarifying information.
- Site visit (if necessary).
- Formal notification to the SA and/or RO of the contractor’s approval, denial or recommendation for approval of the application.

15.6.1 – Standards for Initial and Revalidation Applications

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

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

1. Form CMS-855 *or Form CMS-20134* change of ownership, acquisition/merger, and consolidation applications submitted by the new owner.
2. “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), (c) as a Form CMS-855 *or Form CMS-20134* reactivation, or (d) as a revalidation.
3. Reactivation certification packages (as described in sections 15.27.1.2.1 and 15.27.1.2.2 of this chapter).

Initial and revalidation application timeliness standards shall be reported together. Likewise, initial and revalidation accuracy shall be reported together.

15.6.1.1.1 – Form CMS-855 *and Form CMS-20134* Applications That Require a Site Visit

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

The contractor shall process 80 percent of all Form CMS-855 *and Form CMS-20134* initial and revalidation applications that require a site visit within 80 calendar days of receipt, process 90 percent of all Form CMS-855 *and Form CMS-20134* initial and revalidation applications that require a site visit within 150 calendar days of receipt, and process 95 percent of all Form CMS-855 *and Form CMS-20134* initial and revalidation applications that require a site visit within 210 calendar days of receipt.

15.6.1.1.2 – Form CMS-855 *and Form CMS-20134* Applications That Do Not Require a Site Visit

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

The contractor shall process 80 percent of all Form CMS-855 *and Form CMS-20134* initial and revalidation applications that do not require a site visit within 60 calendar days of receipt, process 90 percent of all Form

CMS-855 *and Form CMS-20134* initial and revalidation applications that do not require a site visit within 120 calendar days of receipt, and process 95 percent of all Form CMS-855 *and Form CMS-20134* initial and revalidation applications that do not require a site visit within 180 calendar days of receipt.

15.6.1.2 - Paper Applications – Accuracy

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

The contractor shall process 98 percent of paper CMS-855 *and Form CMS-20134* initial and revalidation applications in full accordance with all of the instructions in this chapter (with the exception of the timeliness standards identified in sections 15.6.1.1.1 through 15.6.1.1.4 of this chapter) and all other applicable CMS directives.

15.6.1.3 - Web-Based Applications – Timeliness

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

The contractor shall process 90 percent of Form CMS-855 *and Form CMS-20134* Web-based initial and revalidation applications within 45 calendar days of receipt, process 95 percent of Form CMS-855 *and Form CMS-20134* Web-based initial and revalidation applications within 60 calendar days of receipt, and process 99 percent of Form CMS-855 *and Form CMS-20134* Web-based initial and revalidation applications within 90 calendar days of receipt. This process generally includes, but is not limited to:

- Receipt of the provider's certification statement in the contractor's mailroom and forwarding it to the appropriate office for review.
- Verification of the application in accordance with existing instructions.
- Requesting and receiving clarifying information in accordance with existing instructions.
- Supplier site visit (if required).

15.6.1.3.1 – Web-Based Applications That Require a Site Visit

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

The contractor shall process 80 percent of all Form CMS-855 *and Form CMS-20134* Web-based initial and revalidation applications that require a site visit within 80 calendar days of receipt, process 90 percent of all Form CMS-855 *and Form CMS-20134* Web-based initial and revalidation applications that require a site visit within 90 calendar days of receipt, and process 95 percent of all Form CMS-855 *and Form CMS-20134* Web-based initial and revalidation applications that require a site visit within 120 calendar days of receipt. This process generally includes, but is not limited to:

- Receipt of the provider's certification statement in the contractor's mailroom and forwarding it to the appropriate office for review.
- Verification of the application in accordance with existing instructions.
- Requesting and receiving clarifying information in accordance with existing instructions.
- Supplier site visit.

15.6.1.3.2 – Web-Based Applications That Do Not Require a Site Visit

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

The contractor shall process 80 percent of all Form CMS-855 *and Form CMS-20134* Web-based initial and revalidation applications that do not require a site visit within 45 calendar days of receipt, process 90 percent

of all Form CMS-855 Web-based initial and revalidation applications that do not require a site visit within 60 calendar days of receipt, and process 95 percent of all Form CMS-855 Web-based initial and revalidation applications that do not require a site visit within 90 calendar days of receipt. This process generally includes, but is not limited to:

- Receipt of the provider's certification statement in the contractor's mailroom and forwarding it to the appropriate office for review.
- Verification of the application in accordance with existing instructions.
- Requesting and receiving clarifying information in accordance with existing instructions.

15.6.1.4 - Web-Based Applications – Accuracy

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

The contractor shall process 98 percent of Form CMS-855 *and Form CMS-20134* Web-based initial and revalidation applications in full accordance with all of the instructions in this chapter (with the exception of the timeliness standards identified in section 15.6.1.3 above) and all other applicable CMS directives.

15.6.2 – Standards for Changes of Information

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

For purposes of timeliness, the term “changes of information” also includes:

1. Form CMS-855 *and Form CMS-20134* change of ownership, acquisition/merger, and consolidation applications submitted by the old owner
2. Form CMS-588 changes submitted without a need for an accompanying complete Form CMS-855 *or Form CMS-20134* application
3. Form CMS-855R applications submitted independently (i.e., without being part of a Form CMS-855I or Form CMS-855B package)
4. Form CMS-855 *and Form CMS-20134* voluntary terminations

15.6.2.1 - Paper Applications – Timeliness

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

The contractor shall process 80 percent of paper Form CMS-855 *and Form CMS-20134* changes of information within 60 calendar days of receipt, and process 95 percent of paper Form CMS-855 *and Form CMS-20134* changes of information within 120 calendar days of receipt. This process generally includes, but is not limited to, the following activities:

- Receipt of the change request in the contractor's mailroom and forwarding it to the appropriate office for review.
- Prescreening the change request in accordance with existing instructions.
- Creating an L & T record and, if applicable, tying it to an enrollment record in PECOS.
- Verification of the change request in accordance with existing instructions.
- Requesting and receiving clarifying information in accordance with existing instructions.

- Supplier site visit (if necessary).
- Formal notification of the contractor's decision or recommendation (and providing the appropriate appeal rights, as necessary).

15.6.2.2 - Paper Applications – Accuracy

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

The contractor shall process 98 percent of paper Form CMS-855 *and Form CMS-20134* changes of information in full accordance with all of the instructions in this chapter (with the exception of the timeliness standards identified in section 15.6.2.1 above) and all other applicable CMS directives.

15.6.2.3 - Web-Based Applications – Timeliness

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

The contractor shall process 90 percent of all Form CMS-855 *and Form CMS-20134* Web-based change of information applications within 45 calendar days of receipt, and process 95 percent of all such changes of information within 90 calendar days of receipt. This process generally includes, but is not limited to:

- Receipt of the provider's certification statement in the contractor's mailroom and forwarding it to the appropriate office for review. (This obviously does not apply to applications submitted with an electronic signature.)
- Ensuring that the changed information has been verified
- Requesting and receiving clarifying information
- Supplier site visit (if necessary)
- Formal notification to the SA and/or RO of the contractor's approval, denial or recommendation for approval of the application.

15.6.2.4 - Web-Based Applications – Accuracy

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

The contractor shall process 98 percent of Form CMS-855 *and Form CMS-20134* Web-based 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 6.2.3 above) and all other applicable CMS directives.

15.6.3 - General Timeliness Principles

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

Unless stated otherwise in this chapter or in another CMS directive, the principles discussed below apply to all applications discussed in sections 15.6.1 through 15.6.2.3 of this chapter (e.g., change of ownership (CHOW) applications submitted by old and new owners, CMS-588 forms).

A. Clock Stoppages

The processing time clocks identified in sections 15.6.1 and 15.6.2.3 of this chapter cannot be stopped or suspended for any reason. This includes, but is not limited to, the following situations:

- Referring an application to the Office of Inspector General (OIG) or the Zone Program Integrity Contractor.

- Waiting for a final sales agreement (e.g., CHOW, acquisition/merger).
- Waiting for the regional office (RO) to make a provider-based or CHOW determination.
- Referring a provider to the Social Security Administration to resolve a discrepancy involving a social security number.
- Contacting CMS' Provider Enrollment & Oversight Group (PEOG) or an RO's survey/certification staff with a question regarding the application or CMS policy.

Notwithstanding the prohibition on clock stoppages and suspensions, the contractor 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 did not stop from March 31 to April 7. However, the contractor should document its files to explain that it forwarded the question to CMS, the dates involved, and the reason for the referral.

B. Calendar Days

Unless otherwise stated in this chapter, all days in the processing time clock are "calendar" days, not "business days." If the 60th day (for initials) or 45th day (for changes of information) 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 60th day fell on a Saturday/Sunday/holiday and furnish any additional explanation as needed.

C. 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.)

For applications that do not require the submission of an fee, 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.

D. 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:

- Sends its recommendation of approval to the State agency
- Denies the application

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 sends notification to the provider that the change has been processed. If notification to the provider is made via telephone, the cycle ends on the date that the telephone call is made (e.g., the date the voice mail message is left).

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, *and (4) Form CMS-20134 applications* the processing cycle ends on the date that the contractor sends its approval/denial letter to the supplier. For change request approval/denial notifications made via telephone, the cycle ends on the date that the telephone call is made (e.g., the date the voice mail message is left).

For any application that is rejected per existing instructions, the processing time clock ends on the date that the contractor sends notification to the provider that the application has been rejected.

E. PECOS

Unless stated otherwise in this chapter or in another CMS directive, the contractor must create a logging & tracking (L & T) record in PECOS:

- For applications that do not require an application fee, no later than 20 calendar days after its receipt of the provider's application in the contractor's mailroom.
- For applications that require an application fee, no later than 20 calendar days after:
 - The date on which the provider paid the fee – as confirmed by either the Fee Submitter List or the provider's submission of a receipt of payment from Pay.gov, or
 - The date on which PEOG approved the provider's hardship exception request (or, for suppliers of durable medical requirement, prosthetics, orthotics and supplies, the date on which the NSC approved the hardship exception request).

Moreover, the contractor must establish a complete enrollment record in PECOS – if applicable - 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.

The L & T and enrollment record requirements in the previous paragraph apply to all applications identified in sections 15.6.1 through 15.6.2.4 of this chapter (e.g., reassignments, CHOW applications submitted by old and new owners).

In situations where the contractor cannot create an L & T record within 20 days due to missing information (e.g., no NPI was furnished), the contractor shall document the provider file accordingly.

15.7 – Application Review and Verification Activities

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

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

(A) The instructions in sections 15.7 through 15.7.1.6.2 apply to:

- The Form CMS-855A, Form CMS-855B, Form CMS-855I, Form CMS-855R, Form CMS-855O, *and Form CMS-20134*.
- All Form CMS-855 transaction types identified in this chapter (e.g., changes of information, reassignments).

(B) Except for situations where a “processing alternative” applies (see sections 15.7.1.3.1 through 15.7.1.3.4 of this chapter) or unless stated otherwise in this chapter or in another CMS directive, the contractor shall:

- Ensure that the provider has completed all required data elements on the Form CMS-855 (including all effective dates) *or Form CMS-20134* 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 Form CMS-20134*. (The instructions on the Form CMS-855 *and Form 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 Form CMS-855 *or Form CMS-20134*.

(C) The instructions in sections 15.7 through 15.7.1.6.2 are in addition to, and not in lieu of, all other instructions in this chapter.

In general, the application review and verification process is as follows:

1. Contractor receives application
2. Contractor reviews application and verifies data thereon
3. If (a) required data/documentation is missing, (b) data cannot be verified, and/or (3) there are data discrepancies, contractor requests missing/clarifying information from the provider.
4. If applicable, contractor (a) verifies any newly furnished data, or (2) seeks additional data/clarification from provider.
5. Final determination

Sections 15.7.1 through 15.7.1.6.2 are structured so as to generally follow Steps 2 through 5 above.

15.7.1.1 – Receipt/Review of Paper Applications

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

A. Background

The contractor shall begin processing the application once the application fee has been paid (if applicable). This includes, but is not limited to (and subject to the processing alternatives in sections 15.7.1.3.1 through 15.7.1.3.4):

- 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

1. Acknowledgment of Receipt of Application – The contractor may, but is not required to, send out acknowledgment letters or emails.
2. “Not Applicable” – Unless a “processing alternative” applies, the provider cannot write “N/A” in response to a question that requires a “yes” or “no” answer. This is considered an incomplete reply, thus warranting the issuance of a request for missing information.
3. Unsolicited Submission of 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.
4. 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 CMS’ Provider Enrollment Business Function Lead (PEBFL) for guidance.
5. State and Country of Birth – The state of birth and country of birth are optional data elements on the Form CMS-855. 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.
6. Photocopying Pages - The contractor may accept photocopied pages in any Form CMS-855 *or Form CMS-20134* it receives so long as the application contains an original 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, original signatures must be furnished in section 15 of each application.
7. White-Out & Highlighting - The contractor shall not write on or highlight any part of the original Form CMS-855 *or Form 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.

15.7.1.3 – Verification of Data/Processing Alternatives

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

A. Verification - General

1. 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. The general purpose of the verification process is to ensure that all of the data furnished on the Form CMS-855 *or Form 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 15.7.1.3 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 to verify an individual’s identity or SSN.

2. 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 15.7.1.4 through 15.7.1.6.2) 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.

3. Concurrent Reviews

If the contractor receives multiple Form CMS-855s *or Form 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.

4. 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.

B. Processing Alternatives

Sections 15.7.1.3.1 through 15.7.1.3.4 outline special processing rules ("processing alternatives") that 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 15.

15.7.1.3.5 - Processing Alternatives – Form CMS-20134 **(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)**

A. General Processing

The following general alternatives are applicable to all sections of the Form CMS-20134, unless otherwise specified:

1. 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:

a. Any final adverse action data requested in sections 3, 5B, and 6B

b. 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 section 4 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.

c. Tax identification numbers (TIN)

d. NPI-legacy number combinations in Section 4 of the Form CMS-20134

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.

e. Supplier/practitioner type in section 2A of the Form CMS-20134

Data available on a previously submitted CMS-20134 enrollment application, or information currently in PECOS, does not qualify 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.

1. 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.*

2. City, State, and ZIP Code - If an address (e.g., correspondence address, practice location) 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 the Delivery Point Validation in PECOS.

3. Inapplicable Questions - The supplier need not check "no" for questions that obviously do not apply to its supplier type.

4. Administrative Locations - 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 15.7.3 of this chapter.

B. Sectional Processing Alternatives

The processing alternatives in this subsection B are in addition to, and not in lieu of, those in subsection A.

1. Section 1

With the exception of: (1) the voluntary termination checkbox and (2) the effective date of termination, any blank data/checkboxes in section 1 can be verified through any means chosen by the contractor (e.g., email, telephone, fax).

2. Section 2

- All information in section 2B1 (with the exception of the TIN and LBN) can be captured by telephone, fax, email, or Web site.*

3. Section 4

- In section 4A, the type of location checkboxes need not be completed if the type of location is apparent to the contractor. The contractor can confirm the information via telephone, email, 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 administrative 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.*
- 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-20134.

4. Section 7

- *If the date of change for an individual coach is completely blank, the contractor must develop for this information.*

5. Section 8

- *If the telephone number is blank, the number can be verified with the supplier by telephone, email or fax. If the section is blank, including the check box, no additional development is necessary.*

6. Section 13

- *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, email 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 Form CMS-20134.*

7. Section 16

The telephone number can be left blank. No further development is needed.

15.7.1.4.1 – Paper Applications

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

If (1) the provider submits an application with at least one missing required data element, (2) the provider fails to submit at least one required document, (3) submits an invalid certification statement, or (4) the contractor determines that clarification is needed regarding certain information (e.g., particular data cannot be verified or there are data inconsistencies), the contractor shall send a development letter to the provider – preferably via email or fax - that contains, at a minimum, the applicable elements in (a) through (f) below. (See section 15.24 et seq. for model letters.)

(a) 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.

(b) A request that the provider submits the missing data/documentation, clarification, and/or revised certification statement within 30 calendar days.

(c) 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.

(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-855 *or Form CMS-20134* application.)

(d) If missing data is involved, the CMS Web site at which the CMS-855 forms *and Form CMS-20134* can be found. The contractor shall instruct the provider to (1) print out the page(s) containing the missing data; (2) enter the data on the blank page; (3) sign and date a new, blank certification statement; and (4) send it to the contractor. (As an alternative, the contractor can fax the blank page(s) and certification statement to the provider.) The provider need not furnish its initials next to the data element(s) in question.

(Step (d) is not needed if the only missing material is documentation.)

(e) An email address, fax number, and mailing address to which the missing/clarifying data/documentation/correct certification statement can be sent to the contractor.

(f) The name, phone number, and email address of a contact person at the contractor site.

15.7.1.5 – Receiving Missing/Clarifying Data/Documentation

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

The procedures in this section 15.7.1.5 are subject to the processing alternatives identified in sections 15.7.1.3.1 through 15.7.1.3.4 of this chapter.

A. 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.

For Internet-based PECOS applications, the provider may mail its paper certification statement and its documentation separately. They need not be sent in the same package.

B. Format of Furnishing Missing Data

1. 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 Form CMS-20134* page(s) and (2) submit the missing material via mail, fax, or scanned email. A newly signed and dated certification statement must accompany the Form CMS-855 *or Form 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 along with the missing information.

2. 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, email, mail, or the Digital Data Repository (DDR), and/or (3) submit the certification statement via paper or e-signature. (The provider may submit the missing data via the applicable paper Form CMS-855 *or Form 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 or mail along with the missing information.

C. Format of Clarifying Data

In cases where clarifying (as opposed to missing) information is requested, the contractor may accept the clarification by email, 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 email).

If the provided clarification ultimately requires the provider to change or alter data that must be reported on the paper or Web Form CMS-855 *or Form CMS-20134*, the contractor shall instruct the provider via a follow-up email or fax to submit the revised data on the applicable Form CMS-855 *or Form CMS-20134* page or via Internet-based PECOS 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 Form CMS-20134*). The certification statement may be submitted by the provider via scanned email, fax or mail along with the missing information.

Consider the following illustrations:

EXAMPLE 1: The contractor notifies the provider via an emailed letter on March 1 of a discrepancy regarding its ownership information on the Form CMS-855A. The provider emails the contractor on March 3 and explains the discrepancy. Based on this email, 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 email to the provider on March 7 instructing the provider to do so. The provider must submit the revised data on the Form CMS-855 (with a new certification statement) by March 31 (not April 6, or 30 days from the date of the follow-up email).

EXAMPLE 2: The contractor notifies the provider via emailed 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 email (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 emailed letter on March 1 of a discrepancy regarding its ownership information on its paper Form CMS-855A. Determining (based on the contractor's email) 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 email). 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 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.

D. 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.

15.7.1.6.1 – Paper Applications

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

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
- Make a second request for the outstanding missing/clarifying data/documentation and/or an appropriate certification statement. (The request can be made via mail, fax, or email. If the request is sent via email, it need not be in the form of a letter.) The contractor may establish its own deadline for the provider's submission of the remaining data or the certification statement, though it must be at least 7 business days from the date of this second request. In making the request, the contractor must specify: (1) the date of the original request/development letter and the material that was requested therein; (2) the data that is still missing or must be clarified; (3) that a newly-signed certification statement is necessary if the data must be furnished on the Form CMS-855 *or Form CMS-20134* (The certification statement may be submitted via scanned email, fax or mail along with the missing information); (4) the deadline for submission; (5) the address, fax number, and email address to which the data/certification statement can be sent; and (6) the name, phone number, and email address of an appropriate contact person at the contractor site.)

While the contractor is not required to make a second request if the provider fails to timely and fully respond to the development letter, the contractor is encouraged to make an additional request 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 contractor 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.

15.7.1.6.2 – Internet-Based PECOS Applications

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

If, in the contractor's view, the provider failed to submit all of the requested data/documentation and/or failed to submit 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

Make a second request for the outstanding missing/clarifying data/documentation and/or an appropriate certification statement. (The request shall be made via PECOS email.) The contractor can establish its own deadline for the provider's submission of the remaining data, though it must be at least 7 business days from the date of the request. In making the request, the contractor shall specify: (1) the date of the original development email and the material that was requested therein; (2) the data that is still missing or needs to be clarified; (3) that a newly-signed certification statement (either via Internet-based PECOS or paper. (The certification statement may be submitted by the provider via scanned email, fax or mail along with the missing material) is necessary if the data must be furnished on the Form CMS-855 *or Form CMS-20134*; (4) the deadline for submission; (5) the address, fax number, and email address to which the documentation or certification statement can be sent (though the provider should be encouraged to use e-signature and the

DDR); and (6) the name, phone number, and email address of an appropriate contact person at the contractor site.

While the contractor is not required to make a second request if the provider fails to timely and fully respond to the development letter, the contractor is encouraged to make an additional request 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.

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.

15.7.3 – Documentation

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

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 15.7.3. 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 15.7.3 are in addition to, and not in lieu of, all other documentation or document maintenance requirements that CMS has mandated.

A. Written and Telephonic Communications

(For purposes of this section 15.7.3, “written correspondence” includes mailed, faxed, and e-mailed correspondence.)

1. 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 ZPIC, or the OIG

2. Telephonic or Face-to-Face Contact (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 ZPIC 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 CO (e.g., CO's provider enrollment unit) 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 15.8.1 of this chapter, the contractor shall document this. The manner of documentation lies within the contractor's discretion.

B. Verification of Data Elements

Once the contractor has completed its review of the CMS-855 *or Form CMS-20134* (e.g., approved/denied application, approved change request), it shall provide a written statement asserting that it has: (1) verified all data elements on the application, and (2) reviewed all applicable names on the CMS-855 *or Form CMS-20134* against the MED and the System for Access Management (SAM). The statement must be signed and dated. 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 MED 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.

15.7.5 – Special Program Integrity Procedures

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

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

- Changes in the provider's practice location
- Change in the special payment address
- On the Form CMS-588, changes in the provider's bank name, depository routing transit number, or depository account number
- Revalidations and Form CMS-855 *or Form CMS-20134* Reactivations

The instructions in this section 15.7.5 are in addition to, and not in lieu of, all other verification instructions contained in this chapter and in other CMS directives. Also, unless otherwise stated, section 15.7.5 applies to the Form CMS-855A, Form CMS-855B, Form CMS-855I, *and Form CMS-20134*.

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 undertake the following activities:

1. 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.

C. Change of EFT Information

If the provider submits a Form CMS-588 request to change the bank name, depository routing transit number, or depository account number, the contractor shall contact the individual physician/practitioner (for Form CMS-855I enrollees), an authorized or delegated official on record (for Form CMS-855A, Form 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.

D. Revalidations and Form CMS-855 *or Form CMS-20134* Reactivations

When processing a revalidation or Form CMS-855 *or Form CMS-20134* reactivation application, the contractor shall – unless another CMS directive instructs otherwise - the contractor shall abide by the instructions in subsections A and 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.

E. Reassignment of All Benefits

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

F. Potential Identity Theft or Other Fraudulent Activity

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

***15.7.5.2 – Special Procedures for MDPP Suppliers
(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)***

To help ensure that only qualified MDPP suppliers are enrolled in Medicare and only eligible coaches are interacting with MDPP beneficiaries, the contractor shall undertake the activities described below.

A. Recognition Status

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.

15.7.6 - Special Processing Guidelines for Form CMS-855A, Form CMS-855B, Form CMS-855I, and Form CMS-20134 Applications

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

The contractor shall abide by the following:

- If 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 obtain a Form CMS-855A from the CAH II or Form CMS-855B from the group. During this timeframe, the contractor shall not withhold any payment from the group solely on the grounds that a Form CMS-855A or Form CMS-855B has not been completed. Once the group or CAH II's application is received, the contractor shall add the new reassignment; if the Form CMS-855R was not submitted, the contractor shall secure it from the provider or supplier.
- 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 Form CMS-20134* application and a new enrollment record must be created in PECOS. (This does not apply to ambulatory surgical centers and portable x-ray suppliers. These entities can submit a TIN change as a change of information unless a change of ownership is involved. If the latter is the case, the applicable instructions in sections 15.7.8.2.1 through 15.7.8.2.1.2 of this chapter should be followed.)
- If the provider or supplier is adding or changing a practice location and the new location is in another state within the contractor's jurisdiction, the contractor shall ensure that the provider or supplier meets all the requirements necessary to practice in that State (e.g., licensure). A complete Form CMS-855 *or Form CMS-20134* for the new State is not required, though the contractor shall create a new enrollment record in PECOS for the new state.
- All members of a group practice must be entered into PECOS.

15.8.1 – Returns

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

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 Form 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 (PXRSSs), *or MDPP supplier application submissions received between January 1, 2018 and March 31, 2018*).
- 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.
- The provider or supplier submitted an initial application prior to the expiration of a re-enrollment bar.
- The application is to be returned per the instructions in section 15.7.7.1.4 of this chapter.
- The application is not needed for the transaction in question. Two common examples include:
 - An enrolled physician wants to change his/her reassignment of benefits from one group to another group and submits a Form CMS-855I and a Form CMS-855R. As only the Form CMS-855R is needed, the Form CMS-855I shall be returned.
 - A physician who is already enrolled in Medicare submits a Form CMS-855O application, thinking that he must do so in order to refer services for Medicare beneficiaries. The Form CMS-855O can be returned, as the physician is already enrolled via the Form CMS-855I.
- The provider or supplier submitted a revalidation application more than six 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.*

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

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

B. Procedures for Returning the Application

If the contractor returns the application:

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

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

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

If the contractor returns an application, it shall (1) keep the original application and supporting documents and return a copy, (2) make a copy or scan of the application and documents and return the originals to the provider, or (3) 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 may fax or mail it to the provider.

C. Other Impacts of a Return

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

a. Expiration of Timeframe for Reporting Changes - If the contractor returns a change of information or CHOW submission per this section 15.8.1 and the applicable 90-day or 30-day period for reporting the change has expired, the contractor shall send an e-mail to its 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 (1)(a) above after the expiration of said time period unless the provider has resubmitted the change request/CHOW.

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

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

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

15.8.2 –Rejections

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

A. Background

In accordance with 42 CFR § 424.525(a)(1) and (2), the contractor (including the National Supplier Clearinghouse) may reject the provider's application if the provider fails to furnish complete information on the enrollment application - including all necessary documentation - within 30 calendar days from the date the contractor requested the missing information or documentation. For purposes of this policy, this includes situations in which the provider submitted an application that falls into one of the following categories and, upon the contractor's request to submit a new or corrected complete application, the provider failed to do so within 30 days of the request:

(1) The Form CMS-855, *Form 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); (e) for paper Form CMS-855I and Form CMS-855O or Form CMS-855R submissions where the reassignor and/or reassignee physician/non-physician practitioner must sign the form, someone other than the required physician or non-physician practitioner signed the form; or (f) certification statement is missing (paper submissions only).

(2) The submitted paper application is an outdated version of the Form CMS-855 *or Form CMS-20134*.

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

(4) The Form CMS-855 *or Form CMS-20134* was completed in pencil.

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

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

(7) The provider sent in its application or Internet-based PECOS certification statement via fax or email when it was not otherwise permitted to do so. (Refer to section 15.5.14.4 for scenarios when this is permitted).

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

The applications described in (1) through (8) above shall be developed, rather than returned. For instance, if the provider submits an application completed in pencil, the contractor shall request the provider to submit a new application, either in ink or via Internet-based PECOS.

B. Timeframe

The 30-day clock identified in 42 CFR § 424.525(a) starts on the date that the contractor mails, faxes, or emails the pre-screening letter or other request for information to the provider. If the contractor makes a follow-up request for information, the 30-day clock does not start anew; rather, it keeps running from the date the pre-screening letter was sent. However, the contractor has the discretion to extend the 30-day time period if it determines that the provider or supplier is actively working with the contractor to resolve any outstanding issues.

C. Incomplete Responses

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

- The provider submits a Form CMS-855A in which section 3 is blank. On March 1, the contractor requests that section 3 be fully completed. On March 14, the provider submits a completed section 3A. However, section 3B remains blank. The contractor need not make a second request for section 3B to be completed. It can reject the application on March 31, or 30 days after its initial request was made.

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

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

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

E. Other Impacts of a Rejection

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

a. Expiration of Timeframe for Reporting Changes - If the contractor rejects a change of information or CHOW submission per this section 15.8.2 and the applicable 90-day or 30-day period for reporting the change has expired, the contractor shall send an email 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 email referred to in (1)(a) above after the expiration of said time period unless the provider has resubmitted the change request/CHOW.

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

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

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

F. Additional Rejection Policies

1. **Resubmission after Rejection** – If the provider’s application is rejected, the provider must complete and submit a new Form CMS-855 *or Form CMS-20134* (either via paper or Internet-based PECOS) and all necessary documentation.
2. **Applicability** – Unless stated otherwise in this chapter or in another CMS directive, this section 15.8.2 applies to all applications identified in this chapter (e.g., initial applications, change requests, Form CMS-855O applications, Form CMS-588 submissions, change of ownership (CHOW) applications, revalidations, reactivations).
3. **Physicians and Non-Physician Practitioners** – Prior CMS guidance instructed contractors to deny, rather than reject, incomplete applications submitted by physicians and certain non-physician practitioners. This policy no longer applies. Such applications shall be rejected if the physician or practitioner fails to provide the requested information within the designated timeframe.
4. **Notice** – If the contractor rejects an application, it shall notify the provider via letter (sent via mail or email) that the application is being rejected, the reason(s) for the rejection, and how to reapply. Absent a CMS instruction or directive to the contrary, the letter shall be sent to the provider or supplier no later than 5 business days after the contractor concludes that the provider or supplier’s application should be rejected.
5. **Copy of Application** – If the contractor rejects an application, it shall either (1) keep the original application and all supporting documents, or (2) make a copy or scan of the application and documents and return the originals to the provider. If the contractor chooses the former approach and the provider requests a copy of its application, the contractor may fax or mail it to the provider.

15.8.4 – Denials

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

A. Denial Reasons

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 15 as the basis for denial. Except as described in section 15.8.4(B) below 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. *For MDPP suppliers, contractors shall always receive prior approval from PEOG by emailing EnrollmentEscalations@cms.hhs.gov.*

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.

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

The provider or supplier is determined not to be in compliance with the 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:

- a. The provider or supplier does not have a physical business address or mobile unit where services can be rendered.
- b. The provider or supplier does not have a place where patient records are stored to determine the amounts due such provider or other person.
- c. The provider or supplier is not appropriately licensed.

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

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

f. The provider or supplier does not have a valid social security number (SSN) or employer identification number (EIN) for itself, an owner, partner, managing organization/employee, officer, director, medical director, and/or authorized or delegated official.

g. The applicant does not qualify as a provider of services or a supplier of medical and health services. (For instance, the applicant is not recognized by any Federal statute as a Medicare provider or supplier (e.g., marriage counselors.)) An entity seeking Medicare payment must be able to receive reassigned benefits from physicians in accordance with the Medicare reassignment provisions in § 1842(b)(6) of the Act (42 U.S.C. 1395u(b)).

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

i. 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 (e) above – and, as applicable, (c) and (d) - the contractor's denial letter shall cite the appropriate statutory and/or regulatory citation(s) containing the specific licensure/certification/authorization requirement(s) for that provider or supplier type. For a listing of some of these statutes and regulations, refer to section 15.4 et seq. of this chapter.

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

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

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

- Excluded from Medicare, Medicaid, or any other Federal health care program, as defined in 42 CFR §1001.2, in accordance with section 1128, 1128A, 1156, 1842, 1862, 1867 or 1892 of the Social Security Act, or
- Debarred, suspended, or otherwise excluded from participating in any other Federal procurement or non-procurement program or activity in accordance with section 2455 of the Federal Acquisition Streamlining Act.

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

The provider, supplier, or any owner 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 15.27.2(D) 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.

If the contractor is uncertain as to whether a particular felony falls within the purview of 42 CFR §424.530(a)(3), it should contact PEOG via the MACRevocationRequests@cms.hhs.gov mailbox for guidance.

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

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

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

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.

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

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

(ii) The enrolling provider, supplier, or owner (as defined in §424.502) thereof was previously the owner of a provider or supplier that had a Medicare debt that existed when the latter's enrollment was voluntarily terminated, involuntarily terminated, or revoked, and all of the following criteria are met:

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

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

(C) CMS determines that the uncollected debt poses an undue risk of fraud, waste, or abuse.

In making this determination under §424.530(a)(6)(ii), CMS considers the following factors:

- (1) The amount of the Medicare debt.

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

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

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

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

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.

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

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

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

An HHA submitting an initial application for enrollment:

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

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

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

(This denial reason should only be used when the institutional provider fails to submit the application fee after its hardship request was denied. The contractor shall use 42 CFR §424.530(a)(1) as a basis for denial when the institutional provider:

- Does not submit a hardship exception request and fails to submit the application fee within the prescribed timeframes, or
- Submits the fee, but it cannot be deposited into a government-owned account.)

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

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.)

Denial Reason 11 (42 CFR §424.530(a)(11)) – DEA Certificate/State Prescribing Authority Suspension or Revocation

(i) A physician or eligible professional's Drug Enforcement Administration (DEA) Certificate of Registration to dispense a controlled substance is currently suspended or revoked; or

(ii) 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.

B. Denial Letters

1. Prior PEOG Approval Necessary

For cases involving §424.530(a)(4) (Denial Reason 4 above) *or MDPP Suppliers*, the contractor shall obtain approval of both the denial and the denial letter from PEOG via the MACRevocationRequests@cms.hhs.gov mailbox prior to sending the denial letter. PEOG will notify the contractor of its determinations and instruct the contractor as to how to proceed.

2. 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 section 15.24 et seq. of this chapter. Absent a CMS instruction or directive to the contrary, the letter shall be sent to the provider or supplier no later than 5 business days after the contractor concludes that the provider or supplier's application should be denied.

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

C. Post-Denial Submission of Enrollment Application

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

- If the denial was not appealed, the provider or supplier's appeal rights have lapsed, or
- If the denial was appealed, the provider or supplier has received notification that the determination was upheld.

D. 30-Day Effective Date of Denial

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

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

E. Other Impacts of a Denial

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

a. Expiration of Timeframe for Reporting Changes - If the contractor denies a change of information or CHOW submission per this section 15.8.4 and the applicable 90-day or 30-day period for reporting the change has expired, the contractor shall send an e-mail to the MACRevocationRequests@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 (1)(a) above after the expiration of said time period unless the provider has resubmitted the change request/CHOW.

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

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

3. Revalidations – If the contractor denies a revalidation application per this section 15.8.4, the contractor shall – unless an existing CMS instruction or directive dictates otherwise - revoke the provider’s Medicare billing privileges under 42 CFR §424.535(a)(1) if the applicable time period for submitting the revalidation application has expired. If it has not expired, the contractor shall revoke the provider’s billing privileges after the applicable time period expires unless the provider has resubmitted the revalidation application. If the provider has resubmitted the application and the contractor (1) denies it again, (2) returns it per section 15.8.1 of this chapter, or (3) rejects it per section 15.8.2 of this chapter, the contractor shall - unless an existing CMS instruction or directive dictates otherwise – revoke the provider’s billing privileges, assuming the applicable time period has expired.

F. Provider Enrollment Appeals Process

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

15.9.4 - Approval of Medicare Diabetes Prevention Program (MDPP) Suppliers (Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

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 section 15.24.7.1 of this chapter;*
- 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.

15.10.1 – Changes of Information - General Procedures

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

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 Form 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), *and 42 CFR §424.205(d)*, the timeframes for providers to report changes to their Form CMS-855 *or Form CMS-20134* information are as follows:

A. Physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse-midwives; clinical social workers; clinical psychologists; registered dietitians or nutrition professionals; and organizations (e.g., group practices) consisting of any of the categories of individuals identified in this paragraph.): The following changes must be reported within 30 days:

- A change of ownership
- A final adverse action
- A change in practice location

All other informational changes involving the providers listed in this section 15.10.1(A) must be reported within 90 days.

B. All providers and suppliers other than (1) those listed in section 15.10.1(A); (2) suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS); and (3) independent diagnostic testing facilities (IDTFs): Any change of ownership, including a change in an authorized or delegated official, must be reported within 30 days. All other informational changes involving the providers listed in this section 15.10.1(B) must be reported within 90 days.

The reporting requirements for IDTFs can be found in 42 CFR §410.33(g)(2) and *in* section 15.5.19.1(A)(2) of this chapter. Reporting requirements for DMEPOS suppliers can be found in 42 CFR §424.57(c)(2).

Reporting requirements for MDPP suppliers can be found in 42 CFR §424.205(g).

In addition:

- **Unsolicited Additional Information** - 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.

- **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-855 *or Form CMS-*

20134.

- **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; *Form CMS-20134 changes*), the contractor shall (1) furnish written, email, or telephonic confirmation to the provider that the change has been made, and (2) document (per section 15.7.3 of this chapter) 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.

15.10.1.1 – Changes of Information and Complete Form CMS-855 *and Form CMS-20134* Applications

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

A provider must submit a complete Form CMS-855 *or Form 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 Form 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 15.10.1.2(B) 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 section 15.6.1 of this chapter.
- Ensuring that all data elements on the Form CMS-855 *or Form 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 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 Form CMS-20134* change request, the contractor shall not take two separate counts (one initial and one change request) for the transaction.

15.10.1.2 - Incomplete or Unverifiable Changes of Information

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

The contractor shall follow the instructions in this section 15.10.1.2 if a submitted change request cannot be processed to completion.

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 Form 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 15.8.2 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 Integrity Group (PEOG) liaison for guidance. (For instance, if the data involves a change in the provider's lone practice location and the contractor cannot verify the validity of the new site, this clearly raises questions as to the provider's continued compliance with Medicare requirements.)

B. Provider is Not in PECOS

As stated in section 15.10.1.1 of this chapter, if a provider does not have an established enrollment record in PECOS and wants to change any of its existing enrollment or electronic funds transfer (EFT) information, it must submit a complete Form CMS-855 *or Form CMS-20134* before the contractor can effectuate the change. If the provider fails to submit the completed form within the applicable 30-day period, the contractor shall request that the provider revalidate its Medicare enrollment information per 42 CFR §424.515.

15.10.3 – Voluntary Terminations

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

Voluntary terminations shall be processed in accordance with the timeframes in section 15.6.2, et al. of this chapter.

If the termination involves a certified provider or certified supplier, the contractor may terminate the entity without making a recommendation to the State and Regional Office (RO). Within 3 business days after the contractor finishes processing the termination, however, it shall notify the State and RO of this via letter, e-mail, or fax.

Upon receipt of a voluntary termination, the contractor may ask the provider 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 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.

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.

15.11 – Electronic Fund Transfers (EFT)

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

A. General Information

If a provider does not have an established enrollment record in the Provider Enrollment, Chain and Ownership System (PECOS) and wants to change any of its EFT information (e.g., bank routing number), it must submit a complete Form CMS-855 *or Form CMS-20134* before the contractor can effectuate the change. With the exception of the situation described in section (B) below, it is immaterial whether the provider or the bank was responsible for triggering the changed data.

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

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

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

B. Verification

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

- The information submitted on the Form CMS-588 is complete and accurate.
- The provider/supplier submitted (1) a voided check or (2) a letter from the bank verifying the account information.
- The routing number and account number matches what was provided on the Form CMS-588.
- The signature is valid. (**NOTE:** For electronic Form CMS-588 submissions, the provider can either e-sign the form or submit a written signature via the paper Form CMS-588. Paper signatures may be submitted by email, fax or mail (as long as an original Form CMS-588, Form CMS-855, *or Form CMS-20134* signature exist on file for the same individual).

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 Form CMS-20134*.

C. Miscellaneous Policies

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

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

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

3. Sent to the Wrong Unit - If a provider submits an EFT change request to the contractor but not to the latter's enrollment unit, the recipient unit shall forward it to the enrollment staff, which shall then process the change. The enrollment unit is responsible for processing EFT changes. As such, while it may send the original EFT form back to the recipient unit, the enrollment unit shall keep a copy of the EFT form and append it to the provider's Form CMS-855 *or Form CMS-20134* in the file.

4. 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.

5. 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 *or Form CMS-20134*, if applicable) is submitted and approved by the contractor. If such an agreement is not submitted within 90 days after the contractor learned that the account was closed, the contractor shall commence revocation procedures in accordance with the instructions in this chapter. The basis for revocation would be §424.535(a) due to the provider’s failure to comply with the EFT requirements outlined in §424.510(e)(1) and (e)(2).

6. 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.

7. Final Payments – If a non-certified supplier (e.g., physician, ambulance company) voluntarily withdraws from Medicare and needs to obtain its final payments, the contractor shall send such payments to the provider’s EFT account of record. If the account is defunct, the contractor can send payments to the provider’s “special payments” address or, if none is on file, to any of the provider’s practice locations on record. If neither the EFT account nor the aforementioned addresses are available, the provider shall submit a Form CMS-855, *or Form CMS-20134*, Form CMS-588 request identifying where it wants payments to be sent.

8. 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 *or Form CMS-20134* before, they must do so at that time.

15.13 – Existing or Delinquent Overpayments

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

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. To this end, the contractor shall:

- When processing a Form CMS-855A, CMS-855B, *CMS-855S, or CMS-20134* initial or change of ownership application, determine – using a system generated daily listing - whether any of the owners listed in section 5 or 6 of the application has an existing or delinquent Medicare overpayment.
- When processing a Form CMS-855I initial application, determine – using a system generated daily listing - whether the physician or non-physician practitioner has an existing or delinquent Medicare overpayment. (For purposes of this requirement, the term “non-physician practitioner” includes 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.)

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.

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 Smith Medicine as a new supplier. The business will be established as a sole proprietorship. A denial is not warranted because the \$20,000 overpayment was attached to Smith Medicine, not to Jane Smith.

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.

NOTE: The contractors shall also observe the following:

- 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.
- The instructions in this section 15.8.4 apply only to (1) initial enrollments, and (2) new owners in a change of ownership.

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)

- 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 15.8.4, the contractor shall not deny the application based on 42 CFR §424.530(a)(6).

15.14.1 – Non-CMS-855 *and non-CMS-20134* Enrollment Activities *(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)*

There are situations where the contractor processes non-CMS-855 forms, *Form CMS-20134*, 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

Unless specified otherwise in this chapter or another CMS directive, the contractor shall 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. The contractor should track and record all other activities internally.

15.14.2 – Contractor Communications

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

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 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 Form 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) liaison 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 Form CMS-20134* change of information in associate profile situations. It can simply use the Form CMS-855 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.”

15.15 – Internet-based PECOS Applications

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

This section furnishes guidance to contractors on the proper handling and processing of Form CMS-855 *or Form CMS-20134* applications submitted via the Internet (hereinafter referred to as "Internet-based PECOS" applications). Unless otherwise stated:

- The instructions in this section 15.15 apply only to Internet-based PECOS applications.
- The instructions in sections 15.7 through 7.1.6.2 of this chapter take precedence over those in this section 15.15.

A. General Background Information

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

Refer to section 15.5.14 for the certification statement and signature requirements.

C. Application Returns

If the contractor can determine (without actively processing the application) that an application can be returned under section 15.8.1 of this chapter (e.g., was submitted more than 30 days prior to the effective date), the contractor shall return the application without waiting for the arrival of the certification statement.

D. Switch to “In Review” Status

After – and only after - it receives and accepts the provider’s certification statement, the contractor shall: (1) enter the date of signature into the “Certification Date” box in the L & T record, and (2) change the L & T status to “In Review.” The contractor, in other words, shall not initiate any application verification activities prior to its receipt and acceptance of the certification statement and its completion of tasks (1) and (2) in the previous sentence.

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 Form 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, emails) per section 15.7.3 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.

15.17.2 - Effective Date for MDPP Suppliers (Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

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.*

15.19.1 – Application Fees (Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

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-20134*, Form CMS-855S or associated Internet-based Provider Enrollment, Chain and Ownership System (PECOS) enrollment application. A physician, non-physician practitioner, physician group, or non-physician practitioner group that is enrolling as a supplier of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) via the Form CMS-855S application must submit the required application fee with its Form CMS-855S form.

B. Fee

1. Amount

The application fee must be in the amount prescribed by CMS for the calendar year (1) in which the application is submitted (for Internet-based PECOS applications) or (2) of the postmark date (for paper applications). The fee for March 25, 2011 through December 31, 2011 was \$505.00. The fee for January 1, 2016 through December 31, 2016 is \$554.00. Fee amounts for future years will be adjusted by the percentage change in the consumer price index (for all urban consumers) for the 12-month period ending on June 30 of the prior year. CMS will give the contractor and the public advance notice of any change in the fee amount for the coming calendar year.

2. Non-Refundable

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

- a. A hardship exception request that is subsequently approved;
- b. An application that was rejected prior to the contractor’s initiation of the screening process, or
- c. An application that is subsequently denied as a result of the imposition of a temporary moratorium under 42 CFR §424.570.

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

In addition, the fee should be refunded if:

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

3. Format

The provider or supplier must submit the application fee electronically through <https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do>, either via credit card, debit card, or check.

Also, with respect to the application fee requirement:

- The fee is based on the Form CMS-855 *or Form 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 section 2A2 of the application, the hospital indicates that it has a psychiatric unit and a rehabilitation unit. Separate PECOS enrollment records must be created for each unit. However, only one application fee is required because only one Form CMS-855A application was submitted.
- A physician/non-physician practitioner clinic or group practice enrolling via the Form CMS-855B is exempt from the fee even if it is: (1) tribally-owned/operated or (2) hospital-owned. However, if a hospital is adding a physician/non-physician practitioner clinic or group practice to its Form CMS-855A enrollment, a fee is required because the hospital is adding a practice location.

C. Hardship Exception

1. Background

A provider or supplier requesting a hardship exception from the application fee must include with its enrollment application a letter (and any supporting documentation) that describes the hardship and why the hardship justifies an exception. If a paper Form CMS-855 *or Form CMS-20134* 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 19.1(D) below.

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

D. Receipt

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

- a. Determine whether the provider has: (1) paid the application fee via Pay.gov, and/or (2) included a hardship exception request with the application or certification statement.
- b. If the provider:
 - i. Has neither paid the fee nor submitted the hardship exception request, the contractor shall send a letter to the provider notifying it that it has 30 days from the date of the letter to pay the application fee via Pay.gov, and that failure to do so will result in the rejection of the provider's application (for initial enrollments and new practice locations) or revocation of the provider's Medicare billing privileges (for revalidations). The letter shall also state that because a hardship exception request was not submitted with the original application, CMS will not consider granting a hardship exception in lieu of the fee.

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

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

- ii. Has paid the fee but has not submitted a hardship exception request, the contractor shall begin processing the application as normal.
- iii. Has submitted a hardship exception request but has not paid a fee, the contractor shall send the request and all documentation accompanying the request via regular mail, fax, or e-mail to its PEOG BFL. If CMS:
 - a. Denies the hardship exception request, it will notify the provider in the decision letter (on which the contractor will be copied) that the application fee must be paid within 30 calendar days from the date of the letter. During this 30-day period, the contractor shall determine whether the fee has been submitted via Pay.gov. If the fee is not paid within 30 calendar days, the contractor

shall deny the application (initial enrollments and new locations) pursuant to 42 CFR §424.530(a)(9) or revoke the provider's Medicare billing privileges under 42 CFR §424.535(a)(6) (revalidations).

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

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

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

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

E. Year-to-Year Transition

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

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

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

F. Appeals of Hardship Determinations

A provider may appeal 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 (D)(b)(iii)(a) and (iv) above, as applicable. A reconsideration request, in other words, does not stay the execution of the instructions in section 19.1(D) above.

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.

G. Miscellaneous

The contractor shall abide by the following:

1. Paper Checks Submitted Outside of Pay.gov – As stated earlier, all payments must be made via Pay.gov. Should the provider submit an application with a paper check or any other hard copy form of payment (e.g., money order), the contractor shall not deposit the instrument. It shall instead treat the situation as a non-submission of the fee and follow the instructions in (D)(b)(i) or (iii) above (depending on whether a hardship exception request was submitted). When sending the applicable letter requesting payment within 30 days, the contractor shall explain that all payments must be made via Pay.gov, stamp the submitted paper check "VOID," and include the voided paper check with the letter.
2. Practice Locations – DMEPOS suppliers, federally qualified health centers (FQHCs), and independent diagnostic testing facilities (IDTFs) must individually enroll each site. Consequently, the enrollment of each site requires a separate fee. For **all other providers and suppliers** (except physicians, non-physician practitioners, and physician and non-physician practitioner groups, none of which are required to submit the fee), a fee must accompany any application that adds a practice location. (This includes the addition of a hospital unit – such as a psychiatric unit – in section 4 of the Form CMS-855A.) If multiple locations are being added on a single application, however, only one fee is required. The fee for providers and suppliers other than DMEPOS suppliers, FQHCs, and IDTFs is based on the application submission, not the number of locations being added on a single application. *For MDPP suppliers, which have administrative locations and not practice locations, the application fee must only be paid upon initial enrollment and revalidation, and not when an additional administrative location is being added to an initial application.*
3. Other Application Submissions – A provider or supplier need not pay an application fee if the application is:
 - Reporting a change of ownership via the Form CMS-855B, Form CMS-855S, *or Form CMS-20134*. (For providers and suppliers reporting a change of ownership via the Form CMS-855A, the ownership change does not necessitate an application fee if the change does not require the provider or supplier to enroll as a new provider or supplier.)
 - Reporting a change in tax identification number (whether Part A, Part B, or DMEPOS).

- Requesting a reactivation of the provider’s Medicare billing privileges unless the provider had been 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.
- Changing the physical location of an existing practice location (as opposed to reporting an additional/new practice location).

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

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

- Enter the application into PECOS, with the receipt date being the date on which the contractor received the application in its mailroom.
- Indicate in PECOS that a developmental request was made.
- Switch the enrollment record to a “denied” or “rejected” status (as applicable) per section 15.19.1(D).
- Notify the applicant of the rejection or denial in accordance with section 15.19.1(D).

5. 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](https://www.pay.gov) receipt or the [Pay.gov](https://www.pay.gov) tracking ID number; if the fee was paid via ACH Debit, a W-9 is required.

15.19.2.1 – Background

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

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.

A. Limited

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

- 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 15.19.2.5 of this chapter applies) process initial, revalidation, and new location applications in accordance with existing instructions.

B. Moderate

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)
- Revalidating home health agencies (HHAs)
- Revalidating DMEPOS suppliers
- *Revalidating MDPP suppliers*

For providers and suppliers in the “moderate” level of categorical screening, the contractor shall (unless section 15.19.2.2 of this chapter or another CMS directive applies):

1. Process initial, revalidation, and new location applications in accordance with existing instructions; and
2. 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 (NVSC) 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 15.19.2.2.
 - a. Ambulance suppliers, independent clinical laboratories, physical therapists, and physical therapist groups

- 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.
- 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.
- 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

- Initial application - In addition to the site visit discussed in section 15.4.1.1(B)(1) 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.
- 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.
- 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

- 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.
- 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.
- 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

- Initial applications – The NSVC will conduct site visits of initially enrolling IDTFs consistent with section 15.4.19.6 of this chapter.

- Revalidations - The NSVC will conduct site visits of revalidating IDTFs (prior to the contractor’s final decision regarding the revalidation application) consistent with section 15.4.19.6 of this chapter.
 - Code Changes – The NSVC will conduct site visits for IDTF code changes as specified in section 15.4.19.6(B) 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.*

C. High

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*

For providers and suppliers in the “high” level of categorical screening:

1. The contractor shall process the application in accordance with existing instructions; and
2. The NSVC will perform a site visit for newly enrolling HHAs *and MDPP suppliers*. (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.” 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.

NOTE:

- Enrolled DMEPOS suppliers that are adding another location will be classified as “high” for screening purposes. (See section 15.19.2.3 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 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.

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.*

15.19.2.2 - Scope of Site Visit

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

A. 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, the SVC will perform such visits consistent with the procedures outlined in sections 20 and 20.1 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 declaration stating the facts and verifying the completion of the site verification. (The sample declaration identified in section 20.1 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

For MDPP suppliers, the contractor shall check the above criteria as well as:

- *Ensure that the facility is not a private residence*
- *Ensure that signage exists denoting the facility’s legal business or DBA name*

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).

15.19.2.3 – Changes of Information and Ownership

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

A. 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.

B. Moderate and High

Unless otherwise specified in this chapter or in another CMS directive, this section 15.19.2.3(B) applies to providers and suppliers in the "moderate" or "high" level of categorical screening.

1. Addition of Practice *or Administrative* 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) *or submits a Form CMS-20134 request to add an administrative location that results in a new PTAN:*

- The contractor shall process the application in accordance with existing instructions, and
- A site visit shall be performed consistent with section 15.19.2.1 above.

(As explained earlier, a DMEPOS supplier that is adding a new practice location falls within the "high" screening category. *Additionally, an MDPP supplier that is adding an administrative location that does not result in a new PTAN falls within the existing enrollment and a site visit is not required.*)

2. 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 in accordance with existing instructions.

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:

- i. 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 15.19.2.2 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.

- ii. 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 15.19.2.2 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.

3. 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:

- (1) Process the application in accordance with existing instructions, and
- (2) 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 15.26.1 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.

4. 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.

15.19.2.4 – Reactivations

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

A. Form CMS-855 Reactivations

1. 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.

2. 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.

3. 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.

B. Reactivation Certification Packages (RCPs)

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

15.20.1 - Site Verifications

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

(Unless otherwise stated in this chapter or in another CMS directive, this section 15.20.1 only applies to site visits/verifications that are not performed pursuant to sections 15.19.2.1 through 15.19.2.4 of this chapter.)

A. Background

1. Operational Status

When conducting a site verification to determine whether a practice *or administrative* 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.

2. Determining Whether the Provider or Supplier Meets Regulatory Requirements for Its Provider or Supplier Type

When conducting a site verification to determine whether a provider or supplier continues to meet the regulatory provisions for its provider or supplier type, the contractor shall conduct its site verification in a manner which limits the disruption for the provider or supplier.

B. 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.

C. 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.

D. Signed Declaration

The contractor shall also include a signed declaration stating the facts and verifying the completion of the site verification. (A sample declaration is below and may be revised as necessary.) As a reminder, this declaration is only necessary for MAC-performed site visits.

Declaration of (Name of Inspector/Investigator)

In the Case of _____
Provider/Supplier No. _____

I, **(Name of Inspector/Investigator)**, declare as follows:

1. I have personal knowledge of each of the following matters in this Declaration except to those facts alleged on information and belief, and as to those matters, I believe them to be true. I am competent to testify to the following:
2. I am an Investigator for [Insert Contractor Name]. [Insert Contractor Name] is a CMS-contracted [Intermediary/Carrier/A/B Medicare Administrative Contractor (MAC)].
3. I have been trained as an Investigator and Site Inspector by [Insert Contractor Name], and I am knowledgeable of Medicare's compliance statutes, regulations and standards for suppliers enrolled in the Medicare program. I have worked in this capacity for [Insert years] years. During this period, I have conducted over [Insert Number] site inspections of the offices and facilities of providers/suppliers; and since January [Year in which case occurs], I have conducted over [Insert Number] site inspections related to the compliance of suppliers with Medicare's requirements.
4. I prepared the attached document entitled "[Title of Document]," which is the report of my attempts to inspect Petitioner's facility. This report is a true and accurate account of the events that occurred and transpired on the dates described therein. I am capable and willing to testify as a witness at a hearing about the content of this report.
5. The foregoing information is based on my personal knowledge or is information provided to me in my official capacity. I declare under penalty of perjury that this information is true and correct to the best of my knowledge and belief.

Executed this **_(Date)_** day of **_(Month) (Year)_** in **_(City)_**, **_(State)_**.

SIGNATURE OF DECLARANT

E. 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.

15.22.2 – Provider Enrollment Inquiries

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

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 Form CMS-20134* applications (and other general enrollment information) on-line
- Explaining to providers/suppliers which Form CMS-855 *or Form CMS-20134* applications should be completed.

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 *and Form CMS-20134* applications.

15.23.2 – Release of Information

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

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 Form CMS-20134*), delegated official(s) (section 16), contact persons (section 13), or authorized surrogate users. 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 Form 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.

In addition:

- When sending emails, the contractor shall not transmit sensitive data, such as social security numbers or employer identification numbers.
- 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.

15.23.3 – File Maintenance

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

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 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

15.24.5 – Model Revalidation Letter

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

REVALIDATION

[Month dd, yyyy]

[PROVIDER/SUPPLIER NAME | ADDRESS 1, ADDRESS 2 CITY, ST ZIP]

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](https://www.cms.gov/MedicareRevalidation).

What you need to do

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](https://pecos.cms.hhs.gov) 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](#)".

If you need help

Visit go.cms.gov/MedicareRevalidation

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

Sincerely,

[Name], [Title]

15.24.5.3 – Model Revalidation Pend Letter

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

PAYMENT HOLD

[Month dd, yyyy]

[PROVIDER/SUPPLIER NAME | ADDRESS 1, ADDRESS 2 CITY, ST ZIP]

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 [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 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]

15.24.5.4 – Model Revalidation Deactivation Letter

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

STOPPING BILLING PRIVILEGES

[Month dd, yyyy]

[PROVIDER/SUPPLIER NAME | ADDRESS 1, ADDRESS 2 CITY, ST ZIP]

Dear [Provider/Supplier Name],

We have stopped your Medicare billing privileges on [deactivation date], because you haven't revalidated your enrollment record with us, or you didn't respond to our requests for more information. We will not pay any claims after this date.

Every five years, 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 [go.cms.gov/MedicareRevalidation](#).

How to recover your billing privileges

Revalidate your Medicare enrollment record, through [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 go.cms.gov/MedicareRevalidation

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

Sincerely,
[Name], [Title]

15.24.5.5 – Model Revalidation Past-Due Group Member Letter

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

REVALIDATION | Past-Due Group Member

[Month dd, yyyy]

[PROVIDER/SUPPLIER NAME | ADDRESS 1, ADDRESS 2 CITY, ST ZIP]

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.

What your group member needs to do

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

- **Online:** [PECOS](https://pecos.cms.hhs.gov) 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]

15.24.5.6 – Model Deactivation Letter due to Inactive Provider/Supplier Letter *(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)*

STOPPING BILLING PRIVILEGES | Inactive Provider/Supplier

[Month dd, yyyy]

[PROVIDER/SUPPLIER NAME | ADDRESS 1, ADDRESS 2 CITY, ST ZIP]

Dear [Provider/Supplier Name],

We have stopped your Medicare billing privileges on [deactivation date], due to inactivity. We will not pay any claims after this date.

What record has been deactivated

[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>

How to recover your billing privileges

Reactivate your Medicare enrollment record, through 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 need help

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

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

Sincerely,
[Name], [Title]

15.24.5.7 – Model Return Revalidation Letter *(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)*

RETURN REVALIDATION

[Month dd, yyyy]

[PROVIDER/SUPPLIER NAME | ADDRESS 1, ADDRESS 2 CITY, ST ZIP]

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 6 months prior to the provider/suppliers 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 six 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 six 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: <http://www.cms.hhs.gov/MedicareProviderSupEnroll>.

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]

15.24.7.1 – Model Approval Letter

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

[month] [day], [year]

[Provider/Supplier Name]

[Address]

[City] ST [Zip]

Reference # (Contractor Control Number or NPI)

Dear [Provider/Supplier Name]:

We are pleased to inform you that your [initial Medicare enrollment application]/[revalidated Medicare enrollment application]/[change of information request] is approved. This application is for the sole purpose

of ordering and referring items or services for Medicare beneficiaries to other providers and suppliers. Listed below are your National Provider Identifier (NPI) and Provider Transaction Access Number (PTAN).

To start billing, you must use your NPI on all Medicare claim submissions. Because the PTAN is not considered a Medicare legacy identifier, do not report it as an “other” provider identification number to the National Plan and Provider Enumeration System (NPPES).

Your PTAN has been activated and will be the required authentication element for all inquiries to customer service representatives (CSRs), written inquiry units, and the interactive voice response (IVR) system. The IVR allows you to inquire about claims status, beneficiary eligibility and transaction information.

If you plan to file claims electronically, please contact our EDI department at [phone number].

Medicare Enrollment Information

Provider \ Supplier name:	[Name]
Practice location:	[Address]
National Provider Identifier (NPI):	[NPI]
Provider Transaction Access Number (PTAN):	[PTAN]
Specialty:	[Provider specialty]
You are a:	[participating]/[non-participating]
Effective date:	[Effective date or Effective date of termination]
Medicare Year-End Cost Report date:	[Date]
Changed Information:	[List all updates/changes]

Please verify the accuracy of your enrollment information.

You are required to submit updates and changes to your enrollment information in accordance with specified timeframes pursuant to *[42 CFR §424.516 or 42 CFR§424.205]*. Reportable changes include, but are not limited to, changes in: (1) legal business name (LBN)/tax identification number (TIN), (2) *[practice location or administrative locations and/or community settings]*, (3) ownership, (4) authorized/delegated officials, (5) changes in payment information such as electronic funds transfer information and (6) final adverse legal actions, including felony convictions, license suspensions or revocations, an exclusion or debarment from participation in Federal or State health care program, or a Medicare revocation by a different Medicare contractor.

Providers and suppliers may enroll or make changes to their existing enrollment in the Medicare program using the Internet-based Provider Enrollment, Chain and Organization System (PECOS). Go to: www.cms.hhs.gov/MedicareProviderSupEnroll.

Providers and suppliers enrolled in Medicare are required to ensure strict compliance with Medicare regulations, including payment policy and coverage guidelines. CMS conducts numerous types of compliance reviews to ensure providers and suppliers are meeting this obligation. Please visit the Medicare Learning Network at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/index.html> for further information about regulations and compliance reviews, as well as Continuing Medical Education (CME) courses for qualified providers.

Additional information about the Medicare program, including billing, fee schedules, and Medicare policies and regulations can be found at our Web site at [insert contractor’s web address] or the Centers for Medicare & Medicaid Services (CMS) Web site at <http://www.cms.hhs.gov/home/medicare.asp>.

If you disagree with the effective date determination in this letter, you may request a reconsideration before a contractor hearing officer. The reconsideration is an independent review and will be conducted by a person who was 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 the additional information with the reconsideration request that you believe 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 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; you will not have another opportunity to do so unless an administrative law judge specifically allows you to do so under 42 CFR §498.56(e).

The reconsideration request must be signed and dated by the physician, non-physician practitioner or any responsible authorized or delegated official within the entity. Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review.

The reconsideration request should be sent 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]

15.24.8 – Denial Letter Guidance

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

- The contractor must submit one or more of 10 Primary Denial Citations as found in x.x.x 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 a Specific Denial Reason, as appropriate. The Specific Denial Reason 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).*

15.24.8.7 – Denial Example #6 – MDPP Supplier Standards Not Met – Ineligible Coach (Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

April 1, 2018

*MDPP Services, Inc.
2498 Prevention Way
Koloa, Hawaii 96756*

Reference # (Contractor Control Number or NPI)

Dear MDPP Services, Inc.:

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.

If you believe that you are able to correct the deficiencies and establish your eligibility to participate in the Medicare program, you may submit a corrective action plan (CAP) within 30 calendar days after the postmark date of this letter. The CAP should provide evidence that you are in compliance with Medicare requirements and no longer have an ineligible coach on your roster. The CAP request must be signed by the authorized or delegated official within the entity. CAP requests should be sent to:

*Medicare Administrative Contractor, Inc.
1234 Main St. – Attn: Hearing and Appeals, Room 510
Anytown, IL 12345*

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. 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 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; you will not have another opportunity to do so unless an administrative law judge specifically allows you to do so under 42 CFR §498.56(e).

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.

The reconsideration request should be sent to:

*Medicare Administrative Contractor, Inc.
1234 Main St. – Attn: Hearing and Appeals, Room 510
Anytown, IL 12345*

If you have any questions, please contact our office at 601-555-1234 between the hours of 9:00 AM and 5:00 PM.

Sincerely,

*Peaches Barkowicz
Provider Enrollment Analyst
Medicare Administrative Contractor, Inc.*

15.24.9 – Revocation Letter Guidance

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

The contractor:

- Must submit one or more of the Primary Revocation Reasons as found in section 15.27.2 *or the MDPP specific Revocation Reason outlined in 15.27.3.c* 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 a Specific Revocation Reason, as appropriate. The Specific Revocation Reason should state sufficient details so it is clear as to why the provider or supplier is being denied.

15.24.9.5 – Revocation Example #3 – MDPP Supplier Use of an Ineligible Coach

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

June 16, 2018

*MDPP Services, Inc
2498 Prevention Way
Koloa, HI 96756*

Reference # (PTAN #, Enrollment #, Case #, etc.)

Dear MDPP Services, INC:

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.

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.

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.

The reconsideration request should be sent to:

*Medicare Administrative Contractor, Inc.
1234 Main St. – Attn: Hearing and Appeals, Room 510
Anytown, IL 12345*

Pursuant to 42 CFR §424.205(h)(v)(B)(2), Medicare Administrative Contractor, Inc. is establishing a re-enrollment bar for a period of Three (3) years. This enrollment bar only applies to your participation in 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 601-555-1234 between the hours of 9:00 AM and 5:00 PM.

Sincerely,

*Joe Nail
Provider Enrollment Analyst
Medicare Administrative Contractor, Inc.*

15.24.14 – Model Documentation Request Letter

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

[month] [day], [year]

[Provider/Supplier Name]

[Address]

[City] ST [Zip]

Reference # (PTAN #, Enrollment #, Case #, etc.)

Dear [Provider/Supplier Name]:

[Under 42 CFR § 424.516(f)(1), a provider or supplier who 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.]

Or

[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.]

Or

[Under 42 CFR §424.205(g), an MDPP supplier is required to maintain documentation for 10 years from the date of services and to provide access to that documentation pursuant to a CMS or Medicare contractor request.]

Consistent with [§ 424.516(f) [(x)] *or* §424.205(g)], please mail to us copies of the orders for the items or services that were furnished to the following beneficiaries on the dates specified:

[Beneficiary name] [Identification information] [Dates provider/supplier furnished items/services]

[Beneficiary name] [Identification information] [Dates provider/supplier furnished items/services]

(etc.)

The documentation must be received at the following address no later than 30 calendar days after the date of this letter:

[Name of MAC]

[Address]

[City], ST [Zip]

Failure to timely submit this documentation may result in the revocation of your Medicare billing privileges pursuant to 42 CFR § 424.535(a) (10).

[Name]
[Title]
[Company]

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

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

A. Background

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

1. Submit a complete Medicare enrollment application, or
2. Recertify that its enrollment information currently on file with Medicare is correct.

B. Certification Option

1. General Requirements

To utilize option (A)(2) above, the provider or supplier must submit to the contractor (a) a hard copy print-out of its PECOS Web enrollment data, (b) a hard copy Form CMS-855 *or Form CMS-20134* certification statement signed and dated by the enrolled individual practitioner or, as applicable, the provider or supplier's authorized or delegated official, and (c) a letter certifying as to the data's accuracy. The letter must:

- (i) Be on the provider or supplier's letterhead.
- (ii) List the provider or supplier's birth name or legal business name, doing business as name (if applicable), National Provider Identifier, and the Provider Transaction Access Number(s) (PTAN) in the provider or supplier's enrollment record to be reactivated.
- (iii) Must state that the provider is seeking to reactivate his/her/its billing privileges.
- (iv) Be signed and dated by the enrolled individual practitioner or, as applicable, the provider or supplier's authorized or delegated official (who must be the same person who signed the Form CMS-855 *or Form CMS-20134* certification statement).
- (v) Contain the following language:

For Individual Practitioners

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

For Authorized/Delegated Officials

“I, _____, in my capacity as an authorized or delegated official of (provider/supplier), certify on behalf of (provider/supplier) that all of the information contained in (provider/supplier’s) Medicare enrollment record (the record’s PAC ID number) is truthful and accurate. I understand that by this statement and by my signature below, (provider/supplier) is bound by all of the terms and conditions of the attached, signed [Form CMS-855 or Form CMS-20134] certification statement and agrees to abide by them.”

A separate Form CMS-855 or Form CMS-20134 certification statement and letter must be submitted with each PECOS enrollment record (and the PTANs in that record) the provider or supplier seeks to have reactivated. To illustrate, suppose a supplier has three separate enrollments it wants to reactivate. Each enrollment has its own PECOS enrollment record. Two of the records have one PTAN; the third record contains two PTANs. The supplier must submit three separate PECOS Web printouts, three separate certification statements, and three separate letters. (The letter pertaining to the third enrollment record must list both PTANs.) The certification statement and letter should be attached to the PECOS Web printout to which it pertains – meaning, per our example, that there would be three separate “reactivation certification packages” (RCPs). All RCPs must be submitted via mail. They cannot be faxed or e-mailed.

The provider or supplier cannot utilize the certification option and must submit a complete Form CMS-855 or Form CMS-20134 application if:

- There is any information in the provider or supplier’s PECOS Web enrollment record that is not correct.
- The provider or supplier cannot produce a printout of the applicable PECOS Web enrollment record (e.g., provider has no enrollment record in PECOS).
- The provider or supplier cannot otherwise produce a valid RCP.

2. Contractor Processing

Upon receipt of an RCP, the contractor:

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

- Shall review all names listed in the provider’s enrollment record against the Medicare Exclusion Database (MED) and the System for Award Management (SAM).

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

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

- Reserves the right to request a full Form CMS-855 or Form CMS-20134 application if the contractor has reason to believe that any data in the provider’s enrollment record is inaccurate or outdated. However, it shall obtain the approval of its CMS Provider Enrollment Business Function Lead (PEBFL) before making this request.

The contractor need not prescreen the RCP.

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

15.27.1.2.2 – Reactivations - Deactivation for Non-Submission of a Claim

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

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

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

1. General Requirements

If all of the data in the provider or supplier's enrollment record is correct, the provider must submit to the contractor: (a) a hard copy print-out of its PECOS Web enrollment data, (b) a hard copy Form CMS-855 *or Form CMS-20134* certification statement signed and dated by the enrolled individual practitioner or, as applicable, the provider or supplier's authorized or delegated official, (c) the claim data described in section 15.27.1.2.3(B) of this chapter, and (d) a letter certifying as to the data's accuracy. The letter must:

- (i) Be on the provider or supplier's letterhead.
- (ii) List the provider or supplier's birth name or legal business name, doing business as name (if applicable), National Provider Identifier, and the Provider Transaction Access Number(s) (PTAN) in the provider or supplier's enrollment record to be reactivated.
- (iii) Must state that the provider is seeking to reactivate his/her/its billing privileges.
- (iv) Be signed and dated by the enrolled individual practitioner or, as applicable, the provider or supplier's authorized or delegated official (who must be the same person who signed the Form CMS-855 *or Form CMS-20134* certification statement).
- (v) Contain the following language:

For Individual Practitioners

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

For Authorized/Delegated Officials

"I, _____, in my capacity as an authorized or delegated official of (Provider/Supplier), certify on behalf of (Provider/Supplier) that all of the information contained in (Provider/Supplier's) Medicare

enrollment record (the record's PAC ID number) is truthful and accurate. I understand that by this statement and by my signature below, (Provider/Supplier) is bound by all of the terms and conditions of the attached, signed [*Form CMS-855 or Form CMS-20134*] certification statement and agrees to abide by them.”

As explained in section 15.27.1.2.2(A), a separate *Form CMS-855 or Form CMS-20134* certification statement and letter must be submitted with each PECOS enrollment record the provider or supplier seeks to have reactivated. The certification statement and letter should be attached to the PECOS Web printout to which it applies. All such “reactivation certification packages” (RCPs) must be submitted via mail. They cannot be faxed or emailed.

2. Contractor Processing

Upon receipt of an RCP, the contractor:

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

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

- Shall review all names listed in the provider's enrollment record against the Medicare Exclusion Database (MED) and the System for Award Management (SAM).
- Shall ensure that the provider is still appropriately licensed and/or certified (e.g., the contractor can check State Web sites).
- Consistent with section 15.19.2.4 of this chapter, shall perform a site visit if the provider is in the moderate or high screening category.

The contractor need not prescreen the RCP.

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

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

1. General Requirements

If any data in the provider or supplier's enrollment record is incorrect, the provider must submit to the contractor: (a) a hard copy print-out of its PECOS Web enrollment data, (b) applicable hard-copy page(s) of the *Form CMS-855 or Form CMS-20134* containing the corrected information (e.g., new section 8 reporting

a change to the billing company address), (c) a certification statement signed and dated by the enrolled individual practitioner or, as applicable, the provider or supplier's authorized or delegated official, (d) the claim data described in section 15.27.1.2.3(B) of this chapter, and (e) a letter certifying as to the rest of the enrollment data's accuracy. The letter must:

- (i) Be on the provider or supplier's letterhead.
- (ii) List the provider or supplier's birth name or legal business name, doing business as name (if applicable), NPI, and PTAN(s).
- (iii) Must state that the provider is seeking to reactivate his/her/its billing privileges.
- (iv) Be signed and dated by the enrolled individual practitioner or, as applicable, the provider or supplier's authorized or delegated official (who must be the same person who signed the Form CMS-855 *or Form CMS-20134* certification statement).
- (v) Contain the following language:

For Individual Practitioners

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

For Authorized/Delegated Officials

"I, _____, in my capacity as an authorized or delegated official of (provider/supplier), certify on behalf of (provider/supplier) that - with the exception of (list the data elements that are currently incorrect and are being updated via the submitted [Form CMS-855 *or Form CMS-20134*] pages) - all of the information contained in (provider/supplier's) Medicare enrollment record (the record's PAC ID number) is truthful and accurate. I understand that by this statement and by my signature below, (provider/supplier) is bound by all of the terms and conditions of the attached, signed [Form CMS-855 *or Form CMS-20134*] certification statement and agrees to abide by them."

As explained in section 15.27.1.2.2(B), a separate Form CMS-855 *or Form CMS-20134* certification statement and letter must be submitted with each PECOS enrollment record the provider or supplier seeks to have reactivated. The certification statement and letter should be attached to the PECOS Web printout to which it applies. All RCPs must be submitted via mail. They cannot be faxed or emailed.

2. Contractor Processing

Upon receipt of an RCP, the contractor:

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

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

letter refers to the incorrect PAC ID number. The contractor may reject the RCP if the provider fails to furnish the requested material within 30 days of the request.

- Shall review all names listed in the provider's enrollment record against the MED and the SAM.
- Shall ensure that the provider is still appropriately licensed and/or certified (e.g., the contractor can check State Web sites).
- Consistent with section 15.19.2.4 of this chapter, shall perform a site visit if the provider is in the moderate or high screening category.
- Process the changed information in accordance with the instructions in this chapter. The entire RCP transaction (including the changed data) shall, however, be processed as a revalidation.

The contractor need not prescreen the RCP.

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

C. PECOS Web Printout

If the provider or supplier cannot produce a printout of the applicable PECOS Web enrollment record (e.g., provider has no enrollment record in PECOS) or cannot otherwise submit a valid RCP, it must submit a complete Form CMS-855 *or Form CMS-20134* application in order to reactivate its Medicare billing privileges.

15.27.1.2.3 – Reactivations – Miscellaneous Policies

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

A. Full Enrollment Applications

1. For providers that were deactivated for non-billing, the provider may submit a complete Form CMS-855 *or Form CMS-20134* enrollment application in lieu of an RCP. The application may be submitted via paper or PECOS Web.
2. For Form CMS-855 *or Form CMS-20134* reactivation applications, the timeliness requirements in sections 15.6.1 et seq., pertaining to initial enrollment applications apply. The contractor shall – unless a CMS instruction directs otherwise - validate all of the information on the application just as it would with an initial application.
3. Unless stated or indicated otherwise:
 - The term “Form CMS-855 revalidations” *or “Form CMS-20134 revalidations”* as used in this chapter 15 only includes Form CMS-855 *or Form CMS-20134* revalidation applications. It does not include RCPs.
 - The term “revalidation” as used in this chapter 15 includes Form CMS-855 *or Form CMS-20134*

revalidation applications and RCPs.

B. Claims

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

C. Development

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

- The provider may submit the requested documentation to the contractor via scanned email, fax or mail.
- If there are deficiencies in the RCP letter, the provider must submit (1) a new letter, and (2) a newly-signed and dated certification statement (The certification statement may be submitted by the provider via scanned email, fax or mail). The provider cannot mark-up the previous letter and resubmit it.

15.27.2 – Revocations

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

A. Revocation Reasons

(Except as described in section 15.27.2(B)(2) below, the contractor shall not issue any revocation or revocation letter without prior approval from CMS' Provider Enrollment & Oversight Group (PEOG).)

When drafting a revocation letter (which, except as described in section 15.27.2(B)(2) below, must be sent to PEOG via the enrollmentescalations@cms.hhs.gov mailbox for approval), 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.

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

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

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

- b. The provider or supplier does not have a place where patient records are stored to determine the amounts due such provider or other person.
- c. The provider or supplier is not appropriately licensed.
- d. The provider or supplier is not authorized by the federal/state/local government to perform the services that it intends to render.
- e. The provider or supplier does not meet CMS regulatory requirements for the specialty that it is enrolled as.
- f. The provider or supplier does not have a valid social security number (SSN) or employer identification number (EIN) for itself, an owner, partner, managing organization/employee, officer, director, medical director, and/or authorized or delegated official.
- g. The provider or supplier fails to furnish complete and accurate information and all supporting documentation within 60 calendar days of the provider or supplier's notification from CMS or its contractor to submit an enrollment application and supporting documentation, or resubmit and certify to the accuracy of its enrollment information. (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.)
- h. The provider or supplier does not otherwise meet general enrollment requirements.
- i. The provider or supplier has its provider or supplier agreement involuntarily terminated by the CMS regional office (RO) (as evidenced by a tie-in/tie-out notice, CMS-2007, or other notice from the RO/state).

With respect to (e) above – and, as applicable, (c) and (d) - the contractor's revocation letter shall cite the appropriate statutory and/or regulatory citation(s) containing the specific licensure/certification/authorization requirement(s) for that provider or supplier type. For a listing of some of these statutes and regulations, refer to section 15.4 et seq. of this chapter.

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

2. Revocation Reason 2 (42 CFR §424.535(a)(2)) – Excluded/Debarred from Federal Program

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

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

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

If an excluded party is found, the contractor shall notify its CMS PEOG Business Function Lead (PEOG BFL) immediately. PEOG will notify the Contracting Officer's Representative (COR) for the appropriate Zone Program Integrity Contractor. The COR will, in turn, contact the Office of Inspector General's office with the findings for further investigation.

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

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:

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

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

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

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

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

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

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

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

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

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.

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

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

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

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

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

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

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

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

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

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

Abuse of billing privileges includes either of the following:

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

(A) Where the beneficiary is deceased.

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

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

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

(A) The percentage of submitted claims that were denied.

(B) The reason(s) for the claim denials.

(C) 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.

(D) The length of time over which the pattern has continued.

(E) How long the provider or supplier has been enrolled in Medicare.

(F) 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; (3) accumulate all information needed to make such determinations; and (4) prepare and send all revocation letters.)

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

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

With respect to Revocation Reason 9:

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

- If the individual or organization reports a change in practice location more than 30 days after the effective date of the change, the contractor shall not 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).

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

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

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

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

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

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

(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).

13. Revocation Reason 13 (42 CFR §424.535(a)(13)) - DEA Certificate/State Prescribing Authority Suspension or Revocation

(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.

14. Revocation Reason 14 (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.

15. Refer to 15.27.3.c for an additional revocation reason specific to MDPP suppliers alone.

B. Prior PEOG Approval

1. Prior PEOG Approval Necessary

Except as described in section 15.27.2(B)(2) below, the contractor shall obtain approval of both the revocation and the revocation letter from PEOG via the MACRevocationRequests@cms.hhs.gov mailbox prior to sending the revocation letter. During its review, PEOG will also determine (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. PEOG will notify the contractor of its determinations and instruct the contractor as to how to proceed.

2. Prior PEOG Approval 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:

- Situation (a), (c), (d), (e), (g), (h), or (i) under Revocation Reason 1 above

§424.535(a)(6) or (a)(11)

C. Effective Date of Revocations

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

As stated in 42 CFR §424.535(d), if the revocation was due to adverse activity (sanction, exclusion, debt, felony) of an owner, managing employee, an authorized or delegated official, medical director, supervising physician, or other health care personnel of the provider or supplier furnishing Medicare services and/or supplies, the revocation may be reversed (with prior 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 revocation notification. The contractor, however:

- Need not solicit or ask for such proof in its revocation letter. It is up to the provider/supplier to furnish this data on its own volition.
- Has the discretion to determine whether sufficient "proof" exists.

D. Re-enrollment Bar

1. 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 3 years, depending on the severity of the basis for revocation. (Felony convictions, however, always entail a 3-year bar.) Per §424.535(c), the reenrollment bar does not apply if the revocation (1) is based on §424.535(a)(1), and (2) stems from a provider or supplier's failure to respond timely to a revalidation request or other request for information. If both of these conditions are met, no reenrollment bar 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, 2, or 3-year period.

(NOTE: Reenrollment bars apply only to revocations, not to denials. The contractor shall not impose a reenrollment bar following a denial of an application.)

2. 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 3 years).

- §424.535(a)(1) (Noncompliance) -- For licensure issues, 1 year if no billing after loss of license; 3 years if billing after loss of license; 3 years for violation of a Medicare policy (using certification statement)
- §424.535(a)(2) (Provider or Supplier Conduct) – 3 years
- §424.535(a)(3) (Felonies) – 3 years
- §424.535(a)(4) (False or Misleading Information) – 3 years
- §424.535(a)(5) (Onsite Review) – 2 years
- §424.535(a)(6) (Grounds Related to Screening) – 1 year
- §424.535(a)(7) (Misuse of Billing Number) – 3 years
- §424.535(a)(8) (Abuse of Billing) – 3 years
- §424.535(a)(9) (Failure to Report) - 1 year if licensure, practice location, revocation; 3 years if felony or exclusion
- §424.535(a)(10) (Failure to Provide CMS Access) – 1 year
- §424.535(a)(11) (Initial Reserve Operating Funds) – 1 year
- §424.535(a)(12) (Medicaid Termination) – 2 years
- §424.535(a)(13) (Prescribing Authority) – 2 years
- § 424.535(a)(14) (Improper Prescribing Practices) – 3 years

3. 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. 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.

F. 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.

G. Provider Enrollment Appeals Process

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

H. Summary

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

- Preparing a draft revocation letter;
- E-mailing the letter to PEOG via the ProviderEnrollmentRevocations@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
 - Affording appeal rights.

I. 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 its designated PEBFL.

J. Special Instructions Regarding Revocations of Certified Providers and Certified Suppliers

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 section 25 of this chapter.

K. Overpayments Based Upon Revocations

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 when Medicare claims are determined to be ineligible for payment. This date may, but will not always, match the inactive date of the enrollment that is reflected in PECOS and MCS or FISS. The starting date upon which claims are not eligible for reimbursement is what the contractor's shall use to assess an overpayment, not the date the enrollment is inactive according to PECOS and MCS or FISS.

The contractor shall initiate procedures to collect overpayment after the appeal filing timeframe has expired or within 10 days of the final appeal determination by the contractor.

- In accordance with 42 CFR §424.565, if a physician, non-physician practitioner, physician organization or non-physician practitioner organization fails to comply with the reporting requirements specified in 42 CFR §424.516(d)(1)(ii), the contractor may assess an overpayment back to the date of the final adverse action, though said date shall be no earlier than January 1, 2009.

15.27.3 - Other Identified Revocations

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

A. Zone Program Integrity Contractor (ZPIC) Identified Revocations

1. General Procedures

If, through its investigations, the ZPIC 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 ZPIC shall provide PEOG with the information described in (2) below.

PEOG will review the case file and:

- Return the case file to ZPIC for additional development, or
- Consider approving the ZPIC's recommendation for revocation.

If PEOG approves the revocation recommendation, PEOG will: (1) ensure that the applicable Medicare Administrative Contractor (MAC) 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 MAC receives a direct request from a ZPIC 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 ZPIC received prior PEOG approval for the revocation.

2. Revocation Request Data

The revocation request shall contain the following information:

- Provider/supplier name; practice location(s); 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)

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.

C. MDPP Supplier Revocation for Use of an ineligible coach

1. 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 MAC or ZPIC 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 (MAC) 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 MAC receives a direct request from a ZPIC 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 ZPIC received prior PEOG approval for the revocation.

2. 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)*

1. 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.

2. 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.

3. Processing information

Refer to 15.27.2.E-H for additional processing information that also apply to this revocation reason.

15.27.4 - External Reporting Requirements

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

A. Quarterly

Using the existing template, the contractor shall furnish to CMS Provider Enrollment & Oversight Group, Division of Compliance and Appeals (PEOG DCA) via e-mail to ProviderEnrollmentAppeals@cms.hhs.gov the following information for the previous quarter:

- Number of revocations of Form CMS-855A enrollments and the three most frequent reasons for said revocations.
- Number of revocations of Form CMS-855B, Form CMS-855I, *and Form CMS-20134* enrollments and the three most frequent reasons therefore. (Form CMS-855B, Form CMS-855I, *and Form CMS-20134* revocations shall be listed separately.)
- Number of revocations of Form CMS-855S enrollments and the three most frequent reasons for said revocations.
- Total number of appeal cases received
- Total number of appeal cases upheld
- Total number of appeal cases overturned
- The number of upheld cases and the number of overturned cases for the following:
 - Number of enrollment denial appeals
 - Number of Corrective Action Plans (CAPS) arising out of enrollment denial appeals
 - Number of reconsideration requests arising out of enrollment denials appeals
 - Include number withdrawn
 - Include number that further appeal was requested for
 - Include reasons for why the decision was made
 - Number of simultaneous submission of Corrective Action Plans (CAPs) and reconsideration requests arising out of enrollment denial appeals
 - Number of enrollment revocation appeals
 - Number of CAPs arising out of enrollment revocation appeals
 - Number of reconsideration requests received arising out of enrollment revocation appeals
 - Include number withdrawn
 - Include number that further appeal was requested for
 - Include reasons for why the decision was made
 - Number of simultaneous submission of CAPs and reconsideration requests arising out of enrollment revocation appeals
 - Number of effective date appeals
 - Number of fingerprint related appeals

- Number of appeal cases for revocations authorized by CMS

The quarterly reports shall encompass the following time periods:

- October through December
 - Due no later than January 10. If this day falls on a weekend or a holiday, the report must be submitted the following business day.
- January through March
 - Due no later than April 10. If this day falls on a weekend or a holiday, the report must be submitted the following business day.
- April through June
 - Due no later than July 10. If this day falls on a weekend or a holiday, the report must be submitted the following business day.
- July through September
 - Due no later than October 10. If this day falls on a weekend or a holiday, the report must be submitted the following business day.

B. Monthly

Using the existing template, the MAC shall capture the following information for all denied Form CMS-855 *and Form CMS-20134* paper and web applications (to include those entered in PECOS and those not entered in PECOS). *Denials from Form CMS-20134 shall be listed separately:*

- LBN of the provider/supplier
- NPI
- State
- Contractor ID
- The denial reason (For any applications denied using the ‘Other (CMS Only)’ reason in PECOS, the MAC shall specify the denial reason in column U)
- If the denial was entered in PECOS (Y/N)

The reports shall be sent to the Provider Enrollment & Operations Group (with a copy to the MAC’s Contracting Officer’s Representative (COR)) no later than the 15th of each month; the report shall cover the prior month’s denials (e.g., the February report shall cover all January denials).