CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 659	**Date: June 24, 2016**
	Change Request 9635

SUBJECT: Update to Pub. 100-08, Chapter 15

I. SUMMARY OF CHANGES: The purpose of this change request (CR) is to make several revisions to Chapter 15 of Pub. 100-08.

EFFECTIVE DATE: July 26, 2016
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 26, 2016
Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	15/15.4.7 – Medicaid State Agencies
R	15/15.5.2.2 – Correspondence Address and E-mail Addresses
R	15/15.5.15.2 – Form CMS-855A and Form CMS-855B Signatories
R	15/15.5.16 – Delegated Officials
R	15/15.5.17 – Supporting Documents
R	15/15.7.1.3.1 – Processing Alternatives – Form CMS-855B and Form CMS-855I
R	15/15.7.1.3.3 – Processing Alternatives – Form CMS-855O
R	15/15.7.1.3.4 – Processing Alternatives – Form CMS-855R
R	15/15.7.5 – Special Program Integrity Procedures
R	15/15.24.9.1 – Model Revocation Letter for Part B Suppliers and Certified Providers and Suppliers
R	15/15.24.10.2 – Favorable Corrective Action Plan/Reconsideration Decision – Denials
R	15/15.25.1.1 – Corrective Action Plans (CAPs
R	15/15.25.1.2 – Reconsideration Requests – Non-Certified Providers/Suppliers
R	15/15.25.1.3 – Additional Appeal Levels
R	15/15.25.2 - Appeals Involving Certified Providers and Certified Suppliers
R	15/15.25.2.1 – Corrective Action Plans (CAPs)
R	15/15.25.2.2 – Reconsideration Requests – Certified Providers and Certified Suppliers
R	15/15.25.2.3 – Additional Appeal Levels
R	15/15.26.1 – HHA Ownership Changes
R	15/15.27.2 – Revocations

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: 659**	**Date: June 24, 2016**	**Change Request: 9635**

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EFFECTIVE DATE: July26, 2016
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I. GENERAL INFORMATION

A. Background: Pub. 100-08, Chapter 15 contains instructions regarding the processing of Form CMS-855 applications. This CR makes several revisions to Chapter 15 of Pub. 100-08. These changes include, but are not limited to-- (1) Clarifying the process for verifying correspondence telephone numbers; (2) Clarifying the signature submission requirements; (3) Clarifying the supporting documentation requirements; (4) Incorporating new processing alternatives; (5) Correcting citations in a model revocation letter; (6) Clarifying the appeal process; (7) Clarifying Home Health Agency (HHA) 36-month rule policy; and (8) Clarifying revocation requirements.

B. Policy: This CR does not involve any legislative or regulatory policies and is restricted to changes in operational procedures.

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	
9635.1	The contractor shall 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.	X	X	X						NSC
9635.1.1	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.	X	X	X						NSC
9635.2	The contractor shall not develop for the additional page certification statement page containing the certification terms. 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	X	X	X						NSC

Number	Requirement	Responsibility								
		A/B MAC			D M E M A C	Shared-System Maintainers				Other
		A	B	H H H		F I S S	M C S	V M S	C W F	
	the page containing the certification terms.									
9635.3	The contractor shall only request documentation of the provider or supplier's Tax Identification Number (TIN) via the CP-575 in the following scenarios; upon initial enrollment, the addition of a TIN to a 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.	X	X	X						NSC
9635.4	The contractor shall not request a copy of a utility bill in any circumstance.	X	X	X						NSC
9635.5	If an application is submitted with a valid National Provider Identifier (NPI) and Provider Transaction Number (PTAN) combination but the Legal Business Name (LBN) field is blank, an incomplete or inaccurate LBN is submitted, or the applicant includes a DBA name in in section 4 of the Form CMS-855I or section 2 of the Form CMS-855R, and the contractor is able to confirm the correct LBN based on the NPI and PTAN combination provided, the contractor is not required to develop.		X	X						NSC
9635.6	If the Form CMS-855 lacks the Medical or Professional School and/or the year of graduation but the information if disclosed in the supporting documentation submitted with the application or already exists in the Provider Enrollment Chain and Ownership System (PECOS), the contractor is not required to develop further.		X	X						NSC
9635.7	The contactor shall use the model letter in 15.24.9.1.	X	X	X						
9635.8	The contractor shall not accept or process an appeal of a Corrective Action Plan (CAP).	X	X	X						NSC
9635.9	The contractor shall complete all steps associated with the settlement or Administrative Law Judge (ALJ) decision no later than 5 business days from the date it received Provider Enrollment Oversight Group’s (PEOG) instructions.	X	X	X						NSC
9635.10	The contractor shall complete all steps associated with the Departmental Appeals Board (DAB) decision no	X	X	X						NSC

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	later than 5 business days from the date it received PEOG's specific instructions.									
9635.11	When PEOG is processing a CAP, the contractor shall supply PEOG with all requested documentation within 5 business days of the request.	X	X	X						NSC
9635.12	When PEOG is processing a reconsideration request, the contractor shall supply PEOG with all requested documentation within 5 business days of the request.	X	X	X						NSC
9635.13	Contractors shall be aware that the CHOW - 36 month rule pertains to both a single and multiple ownership transactions on the form CMS 855A, including changes of ownership or changes of information, that result in any one individual or organization acquiring greater than 50 percent ownership in the HHA.	X		X						NSC
9635.14	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 contractors 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 Multi-carrier system (MCS) or Fiscal Intermediary Shared System (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 timeframe has expired or after a final appeal determination has been made by the contractor. In addition, the contractor shall initiate procedures to collect overpayment after the claim filing deadline has expired. The contractor shall initiate procedures to collect overpayments within 10 days of the later of the described scenarios.		X							NSC
9635.14.1	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 should		X							NSC

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	assess an overpayment back to the date of the final adverse action, though said date shall be no earlier than January 1, 2009.									

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): Joseph Schultz, 410-786-2656 or Joseph.Schultz@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

15.4.7 - Medicaid State Agencies

(Rev.659, Issued: 06-24- 16, Effective: 07-26-16, Implementation: 07-26-16)

State Medicaid agencies do not have a National Provider Identifier and are not otherwise eligible to enroll in the Medicare program. If a *state* Medicaid agency is enrolled or seeks enrollment as a provider or supplier in the Medicare program, the contractor shall deny or revoke its Medicare billing privileges using, respectively, § 424.530(a)(5) (denials) and *§ 424.535(a)(5)* (revocations) as the basis.

15.5.2.2 – Correspondence Address and E-mail Addresses

(Rev.659, Issued: 06-24- 16, Effective: 07-26-16, Implementation: 07-26-16)

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, the contractor shall develop for this information via the procedures outlined in this chapter. 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. E-mail Addresses

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

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 e-mail address) - the contractor has the discretion to use the contact persons listed in section 13 of the Form CMS-855 for all written and oral communications (e.g., mail, e-mail, telephone) related to the provider's Medicare enrollment. Such communication need not be restricted to a particular enrollment application of the provider's that the contractor is currently processing. Nor is the contractor required (again, unless either CMS or the provider directs otherwise) to send certain materials to the correspondence mailing or e-mail address rather than the contact person's mailing or e-mail address.

15.5.15.2 – Form CMS-855A and Form CMS-855B Signatories

(Rev.659, Issued: 06-24- 16, Effective: 07-26-16, Implementation: 07-26-16)

For *Form* CMS-855A and CMS-855B 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 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 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:

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

2. 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 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 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 appl*ies* 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 – Delegated Officials

(Rev.659, Issued: 06-24- 16, Effective: 07-26-16, Implementation: 07-26-16)

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

A delegated official is an individual to whom an authorized official listed in section 15 of the Form CMS-855 delegates the authority to report changes and updates to the provider's enrollment record *or to sign revalidation applications*. The delegated official 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 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.

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 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 is completed for that person, and (3) an existing 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 change request, the contractor may accept the signature of a delegated official in Section 15 or 16 of the Form CMS-855.

12. 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 appl*ies* 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.

15.5.17 – Supporting Documents

(Rev.659, Issued: 06-24- 16, Effective: 07-26-16, Implementation: 07-26-16)

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 contactor 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.

15.7.1.3.1 – Processing Alternatives – Form CMS-855B and Form CMS-855I

(Rev.659, Issued: 06-24- 16, Effective: 07-26-16, Implementation: 07-26-16)

A. General Processing Alternatives

The following general alternatives are applicable to all sections of the Form CMS-855B and the CMS-855I, unless otherwise specified:

1. Information Disclosed Elsewhere - If a data element on the supplier's Form CMS-855 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-855 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-855, 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, 4A (Form CMS-855I only), 5B (Form CMS-855B only), and 6B of the Form CMS-855
   b. *The applicants* legal business name (LBN) or legal names
   c. Tax identification numbers (TIN)
   d. NPI-legacy number combinations in Section 4 of the Form CMS-855
   e. Supplier/practitioner type (section 2A of the Form CMS-855B and section 2D of the Form CMS-855I)

Data available on a previously submitted CMS-855 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.

2. Licenses

In situations where the supplier is required to submit a copy of a particular professional or business license, certification, registration, or degree but fails to do so, the contractor need not obtain such documentation from the provider if the contractor can verify the information independently. This may be done by: (1) reviewing and printing confirming pages from the applicable state, professional, or school Web site, (2) requesting and receiving from the appropriate state, professional, or educational body written confirmation of the supplier's status therewith, or (3) utilizing another third-party verification source. Similarly, if the provider submits a copy of the applicable license, certification, registration or degree but fails to complete the applicable section of the form, the section need not be completed if the data in question can be verified on the license/certification itself or via any of the three mechanisms described above. *The contractor shall not develop for a correction to the form if the license 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 e-mail, but it must be in writing. Documentation of a verbal conversation between the contractor and the body in question does not qualify as appropriate confirmation.

- This exception only applies to those documents that traditionally fall within the category of licenses, registrations, certifications, or degrees. It does not apply to items such as adverse action documentation, paramedic intercept services documents, etc. Furthermore, the exception is moot in cases where: (1) a particular license/certification is not required by the state, or (2) the license/certification has not been obtained because a state survey has not yet been performed (i.e., for certified suppliers).

3. 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 Finalist in PECOS.

4. Inapplicable Questions - The supplier need not check "no" for questions that obviously do not apply to its supplier type. For instance, a nurse practitioner need not check "no" to question 1(a) in Section 2C of the Form CMS-855I.

5. Clinical Laboratory Improvement Act (CLIA) and Drug Enforcement Agency (DEA) - CLIA and DEA certificates need not be submitted if the applicable CLIA and DEA information was furnished on the Form CMS-855. Likewise, if the aforementioned certificates are furnished but the applicable Form CMS-855 sections are blank, no further development is needed.

6. Practice Locations - Each practice location is to be verified. However, there is no need to separately contact each location on the application. Such verification can be done via the contact person listed on the application; the contact person's verification shall be documented in the provider file pursuant to section 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 (Form CMS-855B and Form CMS-855I)

With the exception of: (1) the voluntary termination checkbox, (2) the effective date of termination, and (3) physician assistant and reassignment data in section 1A of the Form CMS-855I, any blank data/checkboxes in section 1 can be verified through any means chosen by the contractor (e.g., e-mail, telephone, fax).

2. Section 2

a. Form CMS-855B

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

- If the contractor is aware that a particular state does not require licensure/certification and the "Not Applicable" boxes are not checked in section 2A2, no further development is needed.

b. Form CMS-855I

- If blank, "Type of Other Name" and "Gender" can be captured orally.

- If the contractor is aware that a particular state does not require licensure/certification and the "Not Applicable" boxes are not checked in section 2A, no further development is needed.

- In section 2D1, if the supplier uses a checkmark, an "X," or other symbol to identify his/her primary and secondary specialties (as opposed to a "P" or "S"), no additional development is needed.

- When processing a non-physician practitioner's (NPP) application, the contractor need not automatically request a copy of the NPP's degree or diploma (if it is not submitted) if his or her education can be verified through other authorized means; requesting a copy of the degree or diploma should only be done if educational information cannot otherwise be verified.

- *Medical or Professional School and Year of Graduation – If the Form CMS-855 lacks the Medical or Professional School and/or the year of graduation, but the information is disclosed in the supporting documentation submitted with the application or already exists in PECOS, no further development is needed.*

3. Section 4

a. Form CMS-855B

- In section 4A, the type of practice location checkboxes need not be completed if the type of location is apparent to the contractor. The contractor can confirm the information via telephone, e-mail, or fax.

- In section 4B, if neither box is checked and no address is provided, the contractor can contact the supplier by telephone, e-mail, or fax to confirm the supplier's intentions. If the "special payments" address is indeed the same as the practice location, no further development is needed. If, however, the supplier wants payments to be sent to a different address, the address in 4B must be completed via the Form CMS-855.

- In section 4E, if the "Check here" box is not checked and no address is provided, the contractor can contact the supplier by telephone, e-mail or fax to confirm the supplier's intentions. If the base of operations address is the same as the practice location, no further development is needed. If the supplier indicates that the base of operations is at a different location, the address in 4E must be completed via the Form CMS-855.

- In section 4F, if the vehicle certificates are furnished but the applicable Form CMS-855 sections are blank, the contractor can verify via telephone, e-mail or fax that said vehicles are the only ones the supplier has.

b. Form CMS-855I

- *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-855I and the contractor is able to confirm the correct LBN based on the NPI and PTAN combination provided, the contractor is not required to develop.*

- In section 4C, the type of practice location checkboxes need not be completed if the type of location is apparent to the contractor; the contractor can confirm the information via telephone, e-mail or fax.

- In section 4E, if neither box is checked and no address is provided, the contractor can contact the supplier by telephone, e-mail or fax to confirm the supplier's intentions. If the "special payments" address is the same as the practice location, no further development is needed. If, however, the supplier wants payments to be sent to a different address, the address in 4E must be completed via the Form CMS-855.

4. Section 8 (Form CMS-855B and Form CMS-855I) - If the telephone number is blank, the number can be verified with the supplier by telephone, e-mail or fax. If the section is blank, including the check box, no additional development is necessary.

5. Section 13 (Form CMS-855B and Form CMS-855I)

- If this section is completely blank, the contractor need not develop for this information and can simply contact an authorized or delegated official (or, for Form CMS-855I applications, the physician/practitioner).

- If neither box is checked but the contact person information is incomplete (e.g., no telephone number listed), the contractor can either: (1) develop for this information by telephone, e-mail or fax, or (2) contact an authorized or delegated official (or, for Form CMS-855I applications, the physician/practitioner).

6. Section 16 (Form CMS-855B)

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

7. Attachment 1 (Form CMS-855B)

In section D, the "Land," "Air," and "Marine" boxes need not be checked (or developed) if the type of vehicle involved is clear.

8. Attachment 2 (Form CMS-855B)

In section E, the telephone number of the supervising physician can be left blank. No further development is needed.

15.7.1.3.3 – Processing Alternatives – Form CMS-855O

(Rev.659, Issued: 06-24- 16, Effective: 07-26-16, Implementation: 07-26-16)

A. General Processing Alternatives

The following general alternatives are applicable to all sections of the Form CMS-855O, unless otherwise specified:

1. Information Disclosed Elsewhere - If a data element on the supplier's Form CMS-855O application is missing but the information is disclosed (1) elsewhere on the application or (2) in the supporting documentation submitted with the application, the contractor need not obtain the missing data via an updated Form CMS-855O page and a newly-signed certification statement; no further development – not even by telephone – is required. The following information, however, must be furnished in the appropriate section(s) of the Form CMS-855O, even if the data is identified elsewhere on the form or in the supporting documentation:

a. Any final adverse action data requested in section 3
b. Legal names
c. Tax identification number (TIN)
d. NPI-legacy number combinations in section 2 (if applicable)
e. Data in section 1B

Data available on a previously submitted Form CMS-855 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.

2. Licenses

In situations where the supplier is required to submit a copy of a particular professional or business license, certification, registration, or degree but fails to do so, the contractor need not obtain such documentation from the provider if the contractor can verify the information independently. This may be done by: (1) reviewing and printing confirming pages from the applicable state, professional, or school web site, (2) requesting and receiving from the appropriate state, professional, or educational body written confirmation of the supplier's status therewith, or (3) utilizing another third-party verification source. Likewise, if the provider submits a copy of the applicable license, certification, registration or degree but fails to complete the applicable section of the form, the section need not be completed if the data in question can be verified on the license/certification itself or via any of the three mechanisms above.

- The above-referenced written confirmation of the supplier's status can be in the form of a letter, fax, or e-mail, but it must be in writing. Documentation of a verbal conversation between the contractor and the body in question does not qualify as appropriate confirmation.

- This exception only applies to those documents that traditionally fall within the category of licenses, registrations, certifications, or degrees such as adverse action documentation. Furthermore, the exception is moot in cases where a particular license/certification is not required by the state.

3. City, State, and ZIP Code **-** If a particular address lacks a city or state, the contractor can verify the missing data in any manner it chooses. In addition, the contractor can obtain the zip + four from either the U.S. Postal Service or Finalist in PECOS.

4. Drug Enforcement Agency (DEA) - DEA certificates need not be submitted if the applicable DEA information was furnished on the CMS-855. Similarly, if the aforementioned certificates are furnished but the applicable CMS-855 sections are blank, no further development is needed.

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 the voluntary termination checkbox, any blank data/checkboxes in section 1 can be verified through any means chosen by the contractor (e.g., e-mail, telephone, fax).

2. Section 2

- If blank, "Type of Other Name" and "Gender" can be captured orally.

- If the contractor is aware that a particular state does not require licensure/certification and the "Not Applicable" boxes are not checked in section 2C, no further development is needed.

- When processing a non-physician practitioner's (NPP) application, the contractor need not automatically request a copy of the NPP's degree or diploma (if it is not submitted) if his or her education can be verified through other authorized means; requesting a copy of the degree or diploma should only be done if educational information cannot otherwise be verified.

- *Medical or Professional School and Year of Graduation – If the Form CMS-855 lacks the Medical or Professional School and/or the year of graduation, but the information if disclosed in the supporting*

documentation submitted with the application or already exists in PECOS, no further development is needed.

3. Section 4

If the supplier uses a checkmark, an "X," or other symbol to identify his/her primary and secondary specialties (as opposed to a "P" or "S"), no additional development is needed.

4. Section 6

If this section is completely blank, the contractor need not develop for this information and can simply contact the physician or practitioner.

15.7.1.3.4 – Processing Alternatives – Form CMS-855R

(Rev.659, Issued: 06-24- 16, Effective: 07-26-16, Implementation: 07-26-16)

All data elements in sections 1, 2, 3, and 4 must be completed via the CMS-855R.

Regarding section 2:

- *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 2 of the Form CMS-855R, and the contractor is able to confirm the correct LBN based on the NPI and PTAN combination provided, the contractor is not required to develop.*

Regarding section 5:

- If this section is completely blank, the contractor need not develop for this information and can simply contact the party that submitted the form (e.g., the enrolling physician).

- If a contact person is listed, any other missing data (e.g., address, e-mail) can be captured via telephone.

15.7.5 – Special Program Integrity Procedures

(Rev.659, Issued: 06-24- 16, Effective: 07-26-16, Implementation: 07-26-16)

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 Reactivations

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

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

A. Change in Practice Location Address

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

1. 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 and Form CMS-855B changes), or the contact person listed in section 13 (for Form CMS-855A, Form CMS-855B, and Form CMS-855I changes) to verify the change. Hence, if the contractor cannot reach, as applicable, the individual physician/practitioner or an authorized or delegated official, it shall confirm the change with the contact person.

C. Change of EFT Information

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

D. Revalidations and Form CMS-855 Reactivations

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

15.24.9.1 – Model Revocation Letter for Part B Suppliers and Certified Providers and Suppliers

(Rev.659, Issued: 06-24- 16, Effective: 07-26-16, Implementation: 07-26-16)

[Month] [day], [year]

[Provider/Supplier Name]
[Address]
[City] ST [Zip]

Reference # (Contractor Control Number or NPI)

Dear [Provider/Supplier Name]:

Your Medicare privileges are being revoked effective [Date of revocation] for the following reasons:

xx CFR §xxx.(x) [heading]

[Specific reason]

xx CFR §xxx.(x) [heading]

[Specific reason]

(For certified providers and certified suppliers only: Pursuant to 42 CFR §424.535(b), this action will also terminate your corresponding (provider or supplier) agreement.)

If you believe that you are able to correct the deficiencies and establish your eligibility to participate in the Medicare program, and if this revocation is based in whole or in part on §424.535(a)(1), you may submit a corrective action plan (CAP) within 30 calendar days after the postmark date of this letter. (Per 42 CFR §405.8*0*9, a CAP cannot be accepted for revocations based exclusively on reasons other than §424.535(a)(1). If the revocation is for multiple reasons of which one is §424.535(a)(1), the CAP will only be reviewed with respect to the §424.535(a)(1) basis for revocation.) The CAP should provide evidence that you are in compliance with Medicare requirements. The CAP request must be signed and dated by the authorized or delegated official within the entity. CAP requests should be sent to:

(Insert correct address based on whether the MAC or CMS is responsible for reviewing the CAP.

[Name of MAC]		[Centers for Medicare & Medicaid Services]
[Address]	or	[Provider Enrollment & Oversight Group]
[City], ST [Zip]		[7500 Security Blvd.]
		[Mailstop: AR-18-50]
		[Baltimore, MD 21244-1850])

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.

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:

(Insert correct address based on whether the MAC or CMS is responsible for handling the reconsideration.

[Name of MAC]		[Centers for Medicare & Medicaid Services]
[Address]	or	[Provider Enrollment & Oversight Group]
[City], ST [Zip]		[7500 Security Blvd.]
		[Mailstop: AR-18-50]
		[Baltimore, MD 21244-1850])

Pursuant to 42 CFR §424.535(c), [Contractor name] is establishing a re-enrollment bar for a period of [Insert amount of time] that shall begin 30 days after the postmark date of this letter. This 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 [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name]
[Title]
[Company]

15.24.10.2 – Favorable Corrective Action Plan/Reconsideration Decision –Denials

(Rev.659, Issued: 06-24- 16, Effective: 07-26-16, Implementation: 07-26-16)

Provider Enrollment & Oversight Group (PEOG)

Month XX, 2015

Provider/Supplier/Attorney
[Attn:]
Address
City, State Zip

Re: [Corrective Action Plan and/or Reconsideration] Decision
Legal Business Name: [provider/supplier name]
NPI: XXXXXX

Dear [provider/supplier/attorney]:

This letter is in response to the [Corrective Action Plan (CAP) and/or reconsideration] request received by the Centers for Medicare & Medicaid Services (CMS) in response to an enrollment denial effective Month XX, 201X. The initial determination letter by [MAC] was dated Month XX, 201X; therefore, this appeal is

considered timely. The following decision is based on the Social Security Act, Medicare regulations, the CMS manual instructions, evidence in the file, and any information received before this decision was rendered.

DENIAL REASON: 42 CFR§ 424.530(a) (fill reason 1-11)

> *(a)* Reasons for denial. CMS may deny a provider's or supplier's enrollment in the Medicare program for the following reasons:
>
> (Reason 1-11, copied from the Reg: link)

[Insert language from the denial letter stating why they are being denied.]

SUBMITTED DOCUMENTATION [or] SUMMARY OF SUBMITTED DOCUMENTS:

- Exhibit 1:
- Exhibit 2:

CASE ANALYSIS:
All of the documentation in the file for [provider/supplier name] has been reviewed and the decision has been made in accordance with Medicare guidelines, as outlined in 42 CFR §424.53*0*.

[The decision must include: A clear explanation of why PEOG is upholding the denial action in sufficient detail for the provider to understand PEOG's decision and; if applicable: the nature of the provider's deficiencies, the regulatory basis to support each reason for the denial, and an explanation of how the provider/supplier now meets the enrollment criteria or requirements]

[Choose which subheading is applicable- CAP, Reconsideration, or both- and delete the heading not being uses]

Corrective Action Plan:
[Enter text]

Reconsideration:
[Enter text]
[If the CAP is approved, use this sentence: After careful consideration, CMS has approved the CAP submitted and request that the reconsideration be withdrawn.]

DECISION:
[Enter text]

CMS grants [provider/supplier] access to the Medicare Trust Funds (by way or issuance) of a Medicare number.

This decision is a **FAVORABLE DECISION**. To effectuate this decision, CMS will direct [MAC] to allow enrollment and provide instruction, as needed, to complete the enrollment process.

Please forward any questions or concerns to providerenrollmentappeals@cms.hhs.gov.

Sincerely,

[Name]

[Signature]
Health Insurance Specialist
Centers for Medicare & Medicaid Services

cc:
[MAC]
[Provider/Supplier, if represented by an attorney]

15.25.1.1 – Corrective Action Plans (CAPs)

(Rev.659, Issued: 06-24- 16, Effective: 07-26-16, Implementation: 07-26-16)

A. Requirements and Submission of CAPs

The CAP process gives a supplier an opportunity to correct the deficiencies (if possible) that resulted in the denial of its application or the revocation of its billing privileges. The CAP must:

(1) Contain, at a minimum, verifiable evidence that the supplier is in compliance with Medicare requirements;

(2) Be submitted within 30 days from the date of the denial or revocation notice;

(3) Be submitted in the form of a letter that is signed and dated by the individual supplier, the authorized or delegated official, or a legal representative;

(4) For revocations, be based on §424.535(a)(1). Consistent with § 405.809, CAPs for revocations based on grounds other than §424.535(a)(1) shall not be accepted. (For revocations based on multiple grounds of which one is §424.535(a)(1), the CAP may be accepted with respect to (a)(1) but not with respect to the other grounds.) If the supplier submits a CAP that does not comply with this paragraph, the contractor shall notify the supplier via letter or e-mail that it cannot be considered. (If multiple grounds are involved of which one is (a)(1), the contractor shall:

- Only consider the portion of the CAP pertaining to (a)(1), and
- Notify the supplier in its decision letter (or, if the contractor wishes, via letter or e-mail prior to issuing the decision letter) that under §405.809, the CAP was/will be reviewed only with respect to the (a)(1) revocation reason.)

The contractor may create a standard CAP form to be sent with the denial or revocation letter to easily identify it as a CAP when it is returned. The contractor may also accept CAPs via fax or e-mail.

If the submitted CAP does not comply with (1) or (3) above:

- Denials - The contractor need not contact the supplier for the missing information or documentation. It can simply deny the CAP.
- Revocations – The contractor shall not contact the supplier for the missing information or documentation. It shall simply deny the CAP. (Under §405.809(a)(2), the supplier has only one opportunity to correct all deficiencies that served as the basis of its revocation through a CAP.)

The contractor may make a good cause determination so as to accept any CAP that has been submitted beyond the 30-day filing period.

The supplier’s contact person (as listed in section 13 of the Form CMS-855) does not qualify as a “legal representative” for purposes of signing a CAP.

B. Processing and Approval of CAPs

The contractor shall process a CAP within 60 days of receipt. During this period, the contractor shall not toll the filing requirements associated with a reconsideration request.

The CAP shall be considered and processed by a contractor staff person who-- (1) Was not involved in the initial decision to deny or revoke enrollment; and (2) Is not conducting a concomitant reconsideration of the provider's or supplier's denial/revocation. In other words, separate individuals must conduct/perform/review the denial/revocation, the CAP, and the reconsideration. This is to ensure completely independent reviews of all three transactions.

If the contractor approves a CAP, it shall rescind the denial or revocation, issue or restore billing privileges (as applicable), and notify the supplier thereof via letter. For new or restored billing privileges – and unless stated otherwise in another CMS directive or instruction - the effective date is based on the date the supplier came into compliance with all Medicare requirements. Consider the following examples:

1. Denials - A physician's initial enrollment application is denied on March 1. The physician submits a CAP showing that, as of March 20, the physician was in compliance with all Medicare requirements. The effective date of billing privileges should be March 20. The 30-day "backbilling rule" should not be applied in this situation because the rule assumes that the provider was in compliance with Medicare requirements during the 30-day period. This was not the case here. The physician was not in compliance with Medicare requirements until March 20.

2. Revocations – A site visit is conducted of a revalidating ambulance supplier. The supplier is found to be out of compliance with certain enrollment requirements. The supplier's billing privileges were therefore revoked effective April 1. The supplier submitted a CAP showing that – as of April 10 – it was in compliance with all enrollment requirements. The contractor shall apply a new effective date of April 10 to the supplier's Provider Transaction Access Number of April 10. Services furnished during the period when the supplier was out of compliance with Medicare requirements shall not be paid.

For an approved CAP, the contractor shall use the receipt date of the CAP request as the receipt date entered in the Provider Enrollment, Chain and Ownership System.

For DMEPOS suppliers, the effective date is the date it is awarded by the National Supplier Clearinghouse. CMS' approval is required prior to restoring DMEPOS billing privileges.

C. Concurrent Submission of CAP and Reconsideration Request

If a CAP and a reconsideration request (see section 15.25.1.2 below) are submitted concurrently, the contractor shall first process and make a determination on the CAP. The contractor and the reconsideration hearing officer (HO) shall coordinate with one another prior to acting on a CAP or reconsideration request to determine if the other party has received a request.

If the CAP is accepted, the standard approval letter (or, if applicable, a notice of rescission of the revocation) shall be sent to the supplier with a statement that the reconsideration request should be withdrawn.

If the CAP is denied:

- It *cannot* be appealed.
- The contractor shall notify the supplier of the denial via letter.
- The reconsideration request, if submitted, shall be processed. *(The contractor shall not toll the filing requirements associated with a reconsideration request, see section 15.25.1.1 (B) above).*

15.25.1.2 – Reconsideration Requests – Non-Certified Providers/Suppliers

(Rev.659, Issued: 06-24- 16, Effective: 07-26-16, Implementation: 07-26-16)

NOTE: This section 15.25.1.2 does not apply to reconsiderations of revocations based wholly or partially on *§424.535(a)(2), §424.535(a)(3), §424.535(a)(4),* §424.535(a)(8)*, §424.535 (a)(13), and §424.535 (a)(14) and reconsiderations of denials based wholly or partially on §424.530(a)(3)*. Such reconsiderations are addressed in section 15.25.2.2 below.

A. Timeframe for Submission

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

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

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

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

B. Signatures

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

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

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

C. Contractor's Receipt of Reconsideration Request

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

D. Reconsideration Determination

If a timely request for a reconsideration is made, the reconsideration shall be conducted by a HO or senior staff having expertise in provider enrollment and who was not involved in the (1) initial decision to deny or revoke enrollment, or (2) the CAP determination. *In other words, separate individuals must conduct/perform/review the denial/revocation, the CAP, and the reconsideration. This is to ensure completely independent reviews of all three transactions.*

The HO must hold an on-the-record reconsideration and issue a determination within 90 days of the date of the appeal request.

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

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

If the appealing party has additional information that it would like a hearing officer to consider during the reconsideration or, if necessary, an administrative law judge to consider during a hearing, the party must submit that information with its request for reconsideration. This is the party's only opportunity to submit information during the administrative appeals process; the party will not have another opportunity to do so unless an administrative law judge specifically allows the party to do so under 42 CFR §498.56(e).

E. Issuance of Reconsideration Decision

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

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

If the HO overturns the contractor's decision, the contractor shall rescind the denial or revocation, issue or restore billing privileges (as applicable), and notify the supplier thereof via letter. For initial enrollments, the effective date of Medicare billing privileges is based on the date the supplier came into compliance with all Medicare requirements or the receipt date of the application – subject, of course, to any applicable

"backbilling" restrictions. (See section 15.17 of this chapter for more information.) The contractor shall use the receipt date of the reconsideration request as the receipt date entered in the Provider Enrollment, Chain and Ownership System. For DMEPOS suppliers, the effective date is the date it is awarded by the National Supplier Clearinghouse.

F. Withdrawal of Reconsideration Request

The supplier or the individual who submitted the reconsideration request may withdraw the reconsideration request at any time prior to the mailing of the reconsideration decision. The withdrawal request must be in writing, signed, and filed with the Medicare contractor. If the contractor receives such a request, it shall send a letter or e-mail to the supplier acknowledging the receipt of the request and advising that the reconsideration action will be terminated.

G. Reports

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

15.25.1.3 – Additional Appeal Levels

(Rev.659, Issued: 06-24- 16, Effective: 07-26-16, Implementation: 07-26-16)

A. Administrative Law Judge (ALJ) Hearing

CMS, a Medicare contractor, or a supplier dissatisfied with a reconsidered determination is entitled to a hearing before an ALJ. The ALJ has delegated authority from the Secretary of the Department of Health and Human Services (DHHS) to exercise all duties, functions, and powers relating to holding hearings and rendering decisions. Such an appeal must be filed, in writing, within 60 days from receipt of the reconsideration decision. 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

(ALJ requests can also be submitted electronically at https://dab.efile.hhs.gov/.)

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

Upon receipt of a request for an ALJ hearing, an ALJ at the Departmental Appeals Board (DAB) will issue a letter by certified mail to the supplier, CMS and the Regional Office of General Counsel (OGC) acknowledging receipt of an appeals request and detailing a scheduled pre-hearing conference. The OGC will assign an attorney to represent CMS during the appeals process; he/she will also serve as the DAB point of contact. Neither CMS nor the Medicare contractor are required to participate in the pre-hearing conference but should coordinate among themselves and the OGC attorney prior to the pre-hearing to discuss any issues. The Medicare contractor shall work with and provide the OGC attorney with all necessary documentation. This includes compiling and sending all relevant case material to the OGC attorney upon the latter's request within 5 calendar days of said request.

The following are examples of information the Medicare contractor may be asked to provide:

- *A copy of the initial determination letter.*
- *A chronological timeline outlining the processing of applications, the date they began providing services at the newest assigned location, and if there were information request; including the CAP and/or reconsideration request.*
- *The HO's decision; including the provider's CAP or reconsideration request.*
- *A complete copy of Form CMS-855, and any supporting documentation submitted with the provider's application.*
- *All background information and investigative data that the HO used to make their decision. Including any on-site visit reports; the contractor's recommendation for administrative action based on the on-site visit;*
- *Contact information for the person(s) who signed both the revocation and reconsideration letters.*
- *This is not an exhaustive list.*

Any settlement proposals, as a result of the pre-hearing conference, will be addressed with CMS. *If CMS agrees to settle a provider enrollment appeal, CMS will notify the contractor of appropriate next steps (e.g. changing the effective date of billing privileges or reinstating a provider's billing privileges). This may result in PEOG providing specific instructions to the contractor to modify template letter language to appropriately notify the provider of changes to its enrollment status, revocation effective date, or effective date of billing privileges.*

If an ALJ decision is rendered that overturns, modifies the initial determination establishing an effective date, revocation or denial of billing privileges, or remands a case back to CMS, this may also result in PEOG providing specific instructions to the contractor to draft and issue a revised reconsideration decision and/or modify template letter language to appropriately notify the provider of changes to its enrollment status, revocation effective date, or effective date of billing privileges.

The contractor shall complete all steps associated with the settlement or ALJ decision no later than 5 business days from the date it received PEOG's specific instructions.

B. Departmental Appeals Board (DAB) Hearing

CMS or a supplier dissatisfied with the ALJ hearing decision may request a Board review by the DAB. Such a request must be filed within 60 days after the date of receipt of the ALJ's decision. Failure to timely request a DAB review is deemed to be a waiver of all rights to further administrative review.

The DAB will use the information in the case file established at the reconsideration level and any additional evidence introduced at the ALJ hearing to make its determination. The DAB may admit additional evidence into the record if the DAB considers it relevant and material to an issue before it. Before such evidence is admitted, notice is mailed to the parties stating that evidence will be received regarding specified issues. The parties are given a reasonable time to comment and to present other evidence pertinent to the specified issues. If additional information is presented orally to the DAB, a transcript will be prepared and made available to any party upon request.

When CMS receives a decision or order from the DAB, as appropriate, PEOG will notify the contractor of appropriate next steps (i.e. changing an effective date or reinstating a provider's billing privileges). This may also result in PEOG providing specific instructions to the contractor to draft and issue a revised reconsideration decision and/or modify template letter language to appropriately notify the provider of changes to its enrollment status, revocation effective date, or effective date of billing privileges.

The contractor shall complete all steps associated with the DAB decision no later than 5 business days from the date it received PEOG's specific instructions.

C. Judicial Review

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

15.25.2 - Appeals Involving Certified Providers and Certified Suppliers

(Rev.659, Issued: 06-24- 16, Effective: 07-26-16, Implementation: 07-26-16)

Sections 15.25.2.1 through 15.25.2.3 below apply to:

- Providers and suppliers completing the Form CMS-855A
- Ambulatory surgical centers
- Portable x-ray suppliers
- Also, section 15.25.2.2 applies to reconsiderations of revocations based wholly or partially on *§424.535(a)(2), §424.535(a)(3), §424.535(a)(4),* §424.535(a)(8)*, §424.535 (a)(13), and §424.535 (a)(14) and reconsiderations of denials based wholly or partially on §424.530(a)(3)*, regardless of provider or supplier type.

15.25.2.1 – Corrective Action Plans (CAPs)

(Rev.659, Issued: 06-24- 16, Effective: 07-26-16, Implementation: 07-26-16)

A. Submission of CAPs

The CAP process gives a provider or supplier (hereinafter collectively referred to as "providers") an opportunity to correct the deficiencies (if possible) that resulted in the denial of its application or the revocation of its billing privileges. The CAP must:

(1) Contain, at a minimum, verifiable evidence that the provider is in compliance with Medicare requirements;

(2) Be submitted within 30 days from the date of the denial or revocation notice;

(3) Be submitted in the form of a letter that is signed and dated by the individual supplier, the authorized or delegated official, or a legal representative.

(4) For revocations, be based on §424.535(a)(1). Consistent with §405.809, CAPs for revocations based on grounds other than §424.535(a)(1) cannot be accepted. (For revocations based on multiple grounds of which one is §424.535(a)(1), the CAP may be accepted with respect to (a)(1) but not with respect to the other grounds.) *CMS' PEOG*, which processes all CAPs, will notify the provider if a CAP cannot be accepted.

CAP requests must be sent to the following address:

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

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

Also:

- PEOG may make a good cause determination so as to accept any CAP that has been submitted beyond the 30-day filing period.

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

B. Processing and Approval of CAPs

PEOG will process a CAP within 60 days. During this period, *PEOG* will not toll the filing requirements associated with a reconsideration request.
The contractor shall work with and provide PEOG with all necessary documentation.

Examples of information the Medicare contractor will be asked to provide:

- *A copy of the initial determination letter.*
- *A chronological timeline outlining the processing of applications, the date they began providing services at the newest assigned location, and if there were information request; including the CAP and/or reconsideration request.*
- *A complete copy of Form CMS-855, and any supporting documentation submitted with the provider's application.*
- *This is not an exhaustive list.*

The contractor shall supply PEOG with all requested documentation within 5 business days.

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

If *PEOG* denies a CAP, it will notify the provider via letter *(*on which the contractor will be copied*) of the denial and associated appeal rights.*

15.25.2.2 – Reconsideration Requests – Certified Providers and Certified Suppliers

(Rev.659, Issued: 06-24- 16, Effective: 07-26-16, Implementation: 07-26-16)

This section 15.25.2.2 also applies to reconsiderations of revocations based wholly or partially on *§424.535(a)(2), §424.535(a)(3), §424.535(a)(4) or* §424.535(a)(8)*, §424.535 (a)(13), and §424.535 (a)(14), and reconsiderations of denials based wholly or partially on §424.530(a)(3)*, regardless of provider or supplier type.

A. Timeframe for Submission

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

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

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

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

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

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

B. Signatures

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

C. Receipt of Reconsideration Request

Upon receipt of a reconsideration request, PEOG will send a letter to the provider to acknowledge receipt of the request. In its acknowledgment letter, PEOG will advise the provider that the reconsideration will be conducted and a determination issued within 90 days from the date of the request. PEOG will include a copy of the acknowledgment letter in the reconsideration file.

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

D. Reconsideration Determination

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

The HO must determine whether the denial or revocation is warranted based on all of the evidence presented. This includes:

- The initial determination itself,

- The findings on which the initial determination was based,

- The evidence considered in making the initial determination, and

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

The contractor shall work with and provide PEOG with all necessary documentation.

The following are examples of information the Medicare contractor will be asked to provide:

- *A copy of the initial determination letter.*
- *A chronological timeline outlining the processing of applications, the date they began providing services at the newest assigned location, and if there were information request; including the CAP and/or reconsideration request.*
- *A complete copy of Form CMS-855, and any supporting documentation submitted with the provider's application.*
- *This is not an exhaustive list.*

The contractor shall supply PEOG with all requested documentation within 5 business days.

If the appealing party has additional information that it would like a hearing officer to consider during the reconsideration or, if necessary, an administrative law judge to consider during a hearing, the party must submit that information with its request for reconsideration. This is the party's only opportunity to submit information during the administrative appeals process; the party will not have another opportunity to do so unless an administrative law judge specifically allows the party to do so under 42 CFR §498.56(e).

PEOG may not introduce new denial or revocation reasons or change a denial or revocation reason listed in the initial determination during the reconsideration process.

E. Issuance of Reconsideration Decision

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

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

- A summary of the documentation that the provider furnished;

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

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

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

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

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

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

F. Withdrawal of Reconsideration Request

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

15.25.2.3 – Additional Appeal Levels

(Rev.659, Issued: 06-24- 16, Effective: 07-26-16, Implementation: 07-26-16)

A. Administrative Law Judge (ALJ) Hearing

CMS, a Medicare contractor, or a provider dissatisfied with a reconsidered determination is entitled to a hearing before an ALJ. The ALJ has delegated authority from the Secretary of the Department of Health and Human Services (DHHS) to exercise all duties, functions, and powers relating to holding hearings and rendering decisions. Such an appeal must be filed, in writing, within 60 days from receipt of the reconsideration decision. 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

(ALJ requests can also be submitted electronically at https://dab.efile.hhs.gov/.)

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

Upon receipt of a request for an ALJ hearing, an ALJ at the Departmental Appeals Board (DAB) will issue a letter by certified mail to the provider, CMS and the Regional Office of General Counsel (OGC) acknowledging receipt of an appeals request and detailing a scheduled pre-hearing conference. The OGC will assign an attorney to represent CMS during the appeals process; he/she will also serve as the DAB point of contact. Neither CMS nor the Medicare contractor are required to participate in the pre-hearing conference but should coordinate among themselves and the OGC attorney prior to the pre-hearing to discuss any issues. The Medicare contractor shall work with and provide the OGC attorney with all necessary documentation. This includes compiling and sending all relevant case material to the OGC attorney upon the latter's request within 5 calendar days of said request.

The following are examples of information the Medicare contractor may be asked to provide:

- *A copy of the initial determination letter.*
- *A chronological timeline outlining the processing of applications, the date they began providing services at the newest assigned location, and if there were information request; including the CAP and/or reconsideration request.*
- *The HO's decision; including the provider's CAP or reconsideration request.*
- *A complete copy of Form CMS-855, and any supporting documentation submitted with the provider's application.*
- *All background information and investigative data that the HO used to make their decision. Including any on-site visit reports; the contractor's recommendation for administrative action based on the on-site visit;*
- *Contact information for the person(s) who signed both the revocation and reconsideration letters.*
- *This is not an exhaustive list.*

Any settlement proposals, as a result of the pre-hearing conference, will be addressed with CMS. *If CMS agrees to settle a provider enrollment appeal, CMS will notify the contractor of appropriate next steps (e.g. changing the effective date of billing privileges or reinstating a provider's billing privileges). This may*

result in PEOG providing specific instructions to the contractor to modify template letter language to appropriately notify the provider of changes to its enrollment status, revocation effective date, or effective date of billing privileges.

If an ALJ decision is rendered that overturns, modifies the initial determination establishing an effective date, revocation or denial of billing privileges, or remands a case back to CMS, this may also result in PEOG providing specific instructions to the contractor to draft and issue a revised reconsideration decision and/or modify template letter language to appropriately notify the provider of changes to its enrollment status, revocation effective date, or effective date of billing privileges.

The contractor shall complete all steps associated with the settlement or ALJ decision no later than 5 business days from the date it received PEOG's specific instructions.

B. Departmental Appeals Board (DAB) Hearing

The CMS or a provider dissatisfied with the ALJ hearing decision may request a Board review by the DAB. Such a request must be filed within 60 days after the date of receipt of the ALJ's decision. Failure to timely request a DAB review is deemed to be a waiver of all rights to further administrative review.

The DAB will use the information in the case file established at the reconsideration level and any additional evidence introduced at the ALJ hearing to make its determination. The DAB may admit additional evidence into the record if the DAB considers it relevant and material to an issue before it. Before such evidence is admitted, notice is mailed to the parties stating that evidence will be received regarding specified issues. The parties are given a reasonable time to comment and to present other evidence pertinent to the specified issues. If additional information is presented orally to the DAB, a transcript will be prepared and made available to any party upon request.

When CMS receives a decision or order from the DAB, as appropriate, PEOG will notify the contractor of appropriate next steps (i.e. changing an effective date or reinstating a provider's billing privileges). This may also result in PEOG providing specific instructions to the contractor to draft and issue a revised reconsideration decision and/or modify template letter language to appropriately notify the provider of changes to its enrollment status, revocation effective date, or effective date of billing privileges.

The contractor shall complete all steps associated with the DAB decision no later than 5 business days from the date it received PEOG's specific instructions.

C. Judicial Review

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

15.26.1 – HHA Ownership Changes

(Rev.659, Issued: 06-24- 16, Effective: 07-26-16, Implementation: 07-26-16)

A. Background

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

- Enroll in the Medicare program as a new (initial) HHA under the provisions of §424.510, and

- Obtain a State survey or an accreditation from an approved accreditation organization.

For purposes of §424.550(b)(1), a "change in majority ownership" (as defined in 42 CFR §424.502) occurs when an individual or organization acquires more than a 50 percent direct ownership interest in an HHA during the 36 months following the HHA's initial enrollment into the Medicare program or the 36 months following the HHA's most recent change in majority ownership (including asset sales, stock transfers, mergers, or consolidations). This includes an individual or organization that acquires majority ownership in an HHA through the cumulative effect of asset sales, stock transfers, consolidations, or mergers during the 36-month period after Medicare billing privileges are conveyed or the 36-month period following the HHA's most recent change in majority ownership. *This rule pertains to both a single and multiple ownership transactions on the form CMS 855A, including changes of ownership or changes of information, that result in any one individual or organization acquiring greater than 50 percent ownership in the HHA.*

B. Exceptions

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

- The HHA has submitted 2 consecutive years of full cost reports. (For purposes of this exception, low utilization or no utilization cost reports do not quality as full cost reports.)

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

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

- An individual owner of the HHA dies.

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

C. Effective Date

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

- Example 1 – Smith HHA initially enrolls in Medicare effective July 1, 2009. Smith undergoes a change in majority ownership effective September 1, 2011. The provisions of §424.550(b)(1) apply to Smith because it underwent a change in majority ownership within 36 months of its initial enrollment.

- Example 2 – Jones HHA initially enrolls in Medicare effective July 1, 2007. Jones undergoes a change in majority ownership effective February 1, 2011. Section 424.550(b)(1) does not apply to this transaction because it occurred more than 36 months after Jones's initial enrollment. Suppose, however, than Jones undergoes another change in majority ownership effective February 1, 2012. Section 424.550(b)(1) would apply to this transaction because it took place within 36 months after Jones's most recent change in majority ownership (i.e., on February 1, 2011).

- Example 3- Johnson HHA initially enrolls in Medicare effective July 1, 2006. It undergoes a change in majority ownership effective October 1, 2010. This transaction is not affected by §424.550(b)(1) – as enacted in CMS-6010-F – because: (1) its effective date was prior to January 1, 2011, and (2) it occurred more than 36 months after the effective date of Johnson's initial enrollment. Johnson undergoes another change in majority ownership effective October 1, 2012. This change would be affected by §424.550(b)(1) because it occurred within 36 months of the HHA's most recent change in majority ownership (i.e., on October 1, 2010).

- Example 4 – Davis HHA initially enrolls in Medicare effective July 1, 1999. It undergoes its first change in majority ownership effective February 1, 2011. This change is not affected by §424.550(b)(1) because it occurred more than 36 months after Davis's initial enrollment. Davis undergoes another change in majority ownership effective July 1, 2014. This change, too, would be unaffected by §424.550(b)(1), as it occurred more than 36 months after the HHA's most recent change in majority ownership (i.e., on February 1, 2011). Davis undergoes another majority ownership change on July 1, 2016. This change would be impacted by §424.550(b)(1), since it occurred within 36 months of the HHA's most recent change in majority ownership (i.e., on July 1, 2014).

D. Section 424.550(b)(1)'s Applicability

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

1. Step 1 – Change in Majority Ownership

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

- The ownership change was a direct ownership change and not a mere indirect ownership change, and

- The change involves a party assuming a greater than 50 percent ownership interest in the HHA.

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

If the transfer does not qualify as a change in majority ownership, the contractor can process the application normally. If it does qualify, the contractor shall proceed to Step 2:

2. Step 2 – 36-Month Period

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

If the effective date of the transfer does not fall within either of the aforementioned 36-month periods, the contractor may process the application normally. If the transfer's effective date falls within one of these timeframes, the contractor shall proceed to Step 3.

3. Step 3 – Applicability of Exceptions

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

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

- For purposes of this exception, low utilization or no utilization cost reports do not qualify as full cost reports. As stated in *CMS* Pub. 15-2, Provider Reimbursement Manual, Part 2, section 3204, please refer to 42 CFR §413.24(h) for a definition of low Medicare utilization.

- The cost reports must have been consecutive, meaning that they were submitted in each of the 2 years preceding the effective date of the transfer. Submit any request for a cost reporting exception to your Provider Enrollment *& Oversight Group Business Function Lead (PEOG BFL*).

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

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

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

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

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

E. Determination

If the contractor concludes that one of the aforementioned exceptions applies *(and unless a CMS instruction or directive states otherwise)*, it may process the application normally. If no exception applies, the contractor shall refer the case to *its PEOG* BFL for review. Under no circumstances shall the contractor take action against the HHA without the prior approval of PEOG. If PEOG agrees with the contractor's determination, the contractor shall send a letter to the HHA notifying it that, as a result of §424.550(b)(1), the HHA must:

- Enroll as an initial applicant; and

- Obtain a new *s*tate survey or accreditation after it has submitted its initial enrollment application and the contractor has made a recommendation for approval to the State/RO.

As the new owner must enroll as a new provider, the contractor shall also deactivate the HHA's billing privileges if the sale has already occurred. If the sale has not occurred, the contractor shall alert the HHA that it must submit a *Form* CMS-855A voluntary termination application.

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

F. Additional Notes

The contractor is advised of the following:

1. If the contractor learns of an HHA ownership change by means other than the submission of a CMS-855A application, it shall notify its *PEOG BFL* immediately.

2. If the contractor determines, under Step 3 above, that one of the §424.550(b)(2) exceptions applies, the ownership transfer still qualifies as a change in majority ownership for purposes of the 36-month clock. To illustrate, assume that an HHA initially enrolled in Medicare effective July 1, 2010. It undergoes a change in majority ownership effective February 1, 2012. The contractor determined that the transaction was exempt from §424.550(b)(1) because the HHA submitted full cost reports in the previous 2 years. On February 1, 2014, the HHA undergoes another change in majority ownership that did not qualify for an exception. The HHA must enroll as a new HHA under §424.550(b)(1) because the transaction occurred within 36 months of the HHA's most recent change in majority ownership - even though the February 2012 change was exempt from §424.550(b)(1).

15.27.2 – Revocations

(Rev.659, Issued: 06-24- 16, Effective: 07-26-16, Implementation: 07-26-16)

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 MACRevocationRequests@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 *f*ederal/*s*tate/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 *f*ederal 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 *f*ederal 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.

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 timeframe has expired or after a final appeal determination has been made by the contractor. In addition, the contractor shall initiate procedures to collect overpayment after the claim filing deadline has expired. The contractor shall initiate procedures to collect overpayments within 10 days of the later of the described scenarios.

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.