

CMS Manual System

Pub 100-08 Medicare Program Integrity

Transmittal 10611

Department of Health & Human Services (DHHS)

Centers for Medicare & Medicaid Services (CMS)

Date: March 19, 2021

Change Request 11917

Transmittal 10355, dated September 18, 2020, is being rescinded and replaced by Transmittal 10611, dated March 19, 2021, to update the following sections of Pub. 100-08, Chapter 10: 10.2.5(A)(2)(d), 10.2.5(A)(3)(j)(i), 10.4(K)(5)(d), 10.7.10(A)(1), 10.7.10(B)(1), 10.7.10(C), 10.7.10(N), 10.7.11(B)(1), 10.7.11(C), 10.7.11(Q), 10.7.13(A), 10.7.13(B), 10.7.13(C), 10.7.13(D), 10.7.13(E), 10.7.13(F), 10.7.13(G)(1), 10.7.13(G)(2), 10.7.13(G)(3), 10.7.13(G)(4), 10.7.13(H), 10.7.13(I), 10.7.13(J), 10.7.15(A), 10.7.15(D), 10.7.15(E), 10.7.15(F) and 10.7.15(G). All other information remains the same.

SUBJECT: Completion of Removal/Moving of Instructions from Chapter 15 of Publication (Pub.) 100-08 to Chapter 10 of Pub. 100-08

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to complete the removing of instructions found in Chapter 15 of Pub.100-08 and moving those instructions to Chapter 10 of Pub. 100-08.

EFFECTIVE DATE: November 19, 2020

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

IMPLEMENTATION DATE: November 19, 2020

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

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

| R/N/D | CHAPTER / SECTION / SUBSECTION / TITLE |
|--------------|---|
| R | 10/Table of Contents |
| R | 10/10.2/10.2.1/Certified Providers and Suppliers That Enroll Via the Form CMS-855A |
| R | 10/10.2/10.2.2/Suppliers that Enroll Via the Form CMS-855B |
| R | 10/10.2/10.2.3/Individual Practitioners that Enroll Via the Form CMS-855I |
| R | 10/10.2/10.2.4/Other Medicare Part B Services |
| R | 10/10.2/10.2.5/Suppliers That Enroll Via the CMS-855S |
| R | 10/10.4/Medicare Enrollment: Contractor Processing Duties |
| N | 10/10.6/10.6.18/Appeals Process |
| R | 10/10.6/10.6.19/Other Medicare Contractor Duties |
| N | 10/10.7/10.7.7/Application Return, Rejection, and Denial Letters |
| N | 10/10.7/10.7.8/Denial Model Letters |
| N | 10/10.7/10.7.9/Revocation Letters |
| N | 10/10.7/10.7.10/Corrective Action Plan (CAP) Model Letters |
| N | 10/10.7/10.7.11/Reconsideration Request Model Letters |
| N | 10/10.7/10.7.12/Deactivation Model Letters |
| N | 10/10.7/10.7.13/Rebuttal Model Letters |
| N | 10/10.7/10.7.15/Revalidation Notification Letters |
| N | 10/10.7/10.7.17/Model Identity Theft Prevention Letter |
| N | 10/10.7/10.7.18/Model Documentation Request Letter |
| R | 15/Medicare Program Integrity Manual Chapter 15 – Reserved for Future Use |
| D | 15/15.24/15.24.5/Model Revalidation Letters |
| D | 15/15.24/15.24.5.1/Model Revalidation Letter – CHOW Scenario Only |
| D | 15/15.24/15.24.5.2/Model Large Group Revalidation Notification Letter |
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| R/N/D | CHAPTER / SECTION / SUBSECTION / TITLE |
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| R/N/D | CHAPTER / SECTION / SUBSECTION / TITLE |
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| D | 15/15.24/15.24.11.6/Improperly Signed Reconsideration Request Dismissal Model Letter |
| D | 15/15.24/15.24.11.7/Not Eligible to Submit Reconsideration Request Dismissal Model Letter |
| D | 15/15.24/15.24.11.8/Reconsideration Request Signature Development Model Letter |
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| R/N/D | CHAPTER / SECTION / SUBSECTION / TITLE |
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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: 10611 | Date: March 19, 2021 | Change Request: 11917

Transmittal 10355, dated September 18, 2020, is being rescinded and replaced by Transmittal 10611, dated March 19, 2021, to update the following sections of Pub. 100-08, Chapter 10: 10.2.5(A)(2)(d), 10.2.5(A)(3)(j)(i), 10.4(K)(5)(d), 10.7.10(A)(1), 10.7.10(B)(1), 10.7.10(C), 10.7.10(N), 10.7.11(B)(1), 10.7.11(C), 10.7.11(Q), 10.7.13(A), 10.7.13(B), 10.7.13(C), 10.7.13(D), 10.7.13(E), 10.7.13(F), 10.7.13(G)(1), 10.7.13(G)(2), 10.7.13(G)(3), 10.7.13(G)(4), 10.7.13(H), 10.7.13(I), 10.7.13(J), 10.7.15(A), 10.7.15(D), 10.7.15(E), 10.7.15(F) and 10.7.15(G). All other information remains the same.

SUBJECT: Completion of Removal/Moving of Instructions from Chapter 15 of Publication (Pub.) 100-08 to Chapter 10 of Pub. 100-08

EFFECTIVE DATE: November 19, 2020

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

IMPLEMENTATION DATE: November 19, 2020

I. GENERAL INFORMATION

A. Background: This CR will reorganize and complete the move of manual instruction in chapter 15 of Pub. 100-08 to chapter 10 of Pub. 100-08. This CR will organize the sections into more manageable content units that will be easily understood by the providers/suppliers.

B. Policy: This CR does not involve any legislative or regulatory policies.

II. BUSINESS REQUIREMENTS TABLE

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

| Number | Requirement | Responsibility | | | | | | | |
|---------|--|----------------|---|---------|---------|------------------------------|---------|---------|-----------|
| | | A/B MAC | | | D ME | Shared-System Maintainers | | | Oth er |
| | | A | B | HH H | | FI SS | M CS | V MS | |
| 11917.1 | Contractors shall use contents of chapter 10 in lieu of chapter 15. Attachment 1 – Crosswalk 5 is being provided with this CR to assist contractors to determine the exact sections deleted from Chapter 15 and the sections' Chapter 10 reference. | X | X | X | | | | | NS C |
| 11917.2 | Contractors shall approve or deny a Federally Qualified Health Center's (FQHC's) initial application. | X | | | | | | | |

| Number | Requirement | Responsibility | | | | | | | |
|---------------|---|----------------|---|---------|--------------------|------------------------------|---------|---------|-------------|
| | | A/B MAC | | | D ME M AC | Shared-System Maintainers | | | |
| | | A | B | HH H | | FI SS | M CS | V MS | C W F |
| 11917.2.1 | Contractors shall inform the Provider Enrollment & Oversight Group (PEOG) via the MedicareProviderEnrollment @cms.hhs.gov email box using the subject line: “S&C – FQHC Approval” of the decision on a FQHC initial application. | X | | | | | | | |
| 11917.2.1.1 | Contractors shall provide a copy of the FQHC’s CMS-855A or PECOS Application Data Report and all supporting documentation, a copy of the FQHC’s CMS-177, the FQHC’s HRSA documentation (unless the FQHC is an Indian Health Services (IHS) provider and include the date the FQHC’s application was complete. | X | | | | | | | |
| 11917.2.1.1.1 | Contractors shall consider the processing clock stopped once the application has been forwarded to PEOG. | X | | | | | | | |
| 11917.2.1.2 | When approving a FQHC, PEOG will provide the FQHC’s CMS Certification Number and effective date following a review of the application, CMS-177 and the FQHC’s HRSA documentation (unless the FQHC is an Indian Health Services (IHS) provider. | | | | | | | | C MS |
| 11917.2.2 | Contractors shall deny an FQHC’s initial application if the FQHC isn’t found to be in compliance with 42 CFR Part 405 Subpart X, and Part 491, as described in §405.2434(a). | X | | | | | | | |

| Number | Requirement | Responsibility | | | | | | | |
|---------------|---|-----------------------|---|---------|--------------------|------------------------------|---------|---------|-------------|
| | | A/B MAC | | | D ME M AC | Shared-System Maintainers | | | |
| | | A | B | HH H | | FI SS | M CS | V MS | C W F |
| 11917.2.3 | If the change of information includes a location change, contractors shall review the HRSA Data Warehouse, https://data.hrsa.gov/tools/shortage-area , to determine whether the location falls within a shortage area. | X | | | | | | | |
| 11917.2.3.1 | If the FQHC is found to reside in a shortage area, the contractor shall process the change of information application, and the contractor shall approve the location change and inform PEOG of the approval. | X | | | | | | | |
| 11917.2.3.2 | Contractors should consult the appropriate CMS Location (formerly the CMS Regional Office) regarding this determination prior to making a decision should any questions arise during processing. | X | | | | | | | |
| 11917.2.3.3 | If the contractor does not approve of the location change, (if the FQHC was found to no longer reside in a shortage area, the FQHC no longer met the requirements noted in Business Requirement 11917.2.2 or another reason for denial is discovered), the contractor shall deny the application stating that the provider no longer meets regulations as an FQHC and the FQHC's enrollment shall be deactivated. | X | | | | | | | |
| 11917.2.4 | If approving the FQHC's location change, the contractor does not issue a recommendation of approval to the CMS Location | X | | | | | | | |

| Number | Requirement | Responsibility | | | | | | | | Other |
|---------------|--|-----------------------|---|---------|--------------------|------------------------------|---------|---------|-------------|--------------|
| | | A/B MAC | | | D ME M AC | Shared-System Maintainers | | | | |
| | | A | B | HH H | | FI SS | M CS | V MS | C W F | |
| | Reconsideration Request model letters. | | | | | | | | | |
| 11917.3.6 | Contractors shall follow/be aware of the instructions in section 10.7.12 of Chapter 10 in Pub. 100-08 regarding the Deactivation model letters. | X | X | X | | | | | | NS C |
| 11917.3.7 | Contractors shall follow/be aware of the instructions in section 10.7.13 of Chapter 10 in Pub. 100-08 regarding the Rebuttal model letters. | X | X | X | | | | | | NS C |
| 11917.3.8 | Contractors shall follow/be aware of the instructions in section 10.7.15 of Chapter 10 in Pub. 100-08 regarding the Revalidation Notification model letters. | X | X | X | | | | | | NS C |
| 11917.3.9 | Contractors shall follow/be aware of the instructions in section 10.7.16 of Chapter 10 in Pub. 100-08 regarding the model letters for claims against surety bonds. | | | | X | | | | | |
| 11917.3.10 | Contractors shall follow/be aware of the instructions in section 10.7.17 of Chapter 10 in Pub. 100-08 regarding the identity theft prevention model letters. | X | X | X | | | | | | NS C |
| 11917.3.11 | Contractors shall follow/be aware of the instructions in section 10.7.18 of Chapter 10 in Pub. 100-08 regarding the model documentation request letters. | X | X | X | | | | | | NS C |

III. PROVIDER EDUCATION TABLE

| Number | Requirement | Responsibility | | |
|--------|-------------|----------------|---|------------|
| | | A/B MAC | | DME MAC |
| | | A | B | |
| | 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): Andrew Stouder, 410-786-0222 or Andrew.Stouder@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: 1

Medicare Program Integrity Manual

Chapter 10 - Medicare Enrollment

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(Rev. 10611; Issued: 03-19-21)

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- 10.7.10 – Corrective Action Plan (CAP) Model Letters*
- 10.7.11 – Reconsideration Request Model Letters*
- 10.7.12 – Deactivation Model Letter*
- 10.7.13 – Rebuttal Model Letters*
- 10.7.15 – Revalidation Notification Letters*
- 10.7.17 – Model Identity Theft Prevention Letter*
- 10.7.18 – Model Documentation Request Letter*

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

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

A. Community Mental Health Centers (CMHCs)

1. General Background Information

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

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

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

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

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

While the CMHC generally has the option to furnish services under arrangement, there is actually an instance where the facility must do so. If the CMHC is located in a State that prohibits CMHCs from furnishing screening services (service #4 above), it must contract with another entity to have the latter perform the services. Any such arrangement must be approved by the regional office (RO). (See Pub. 100-07, State Operations Manual (SOM), chapter 2, section 2250, for additional information on core services and arrangements.)

A CMHC must provide mental health services principally to individuals who reside in a defined geographic area (service area); that is, it must service a distinct and definable community. A CMHC (or CMHC site) that operates outside of this specific community must – unless the RO holds otherwise - have a separate provider agreement/number and enrollment, and must individually meet all Medicare requirements.

2. For more information on CMHCs, refer to:

- Section 1861(ff) of the Social Security Act
- 42 CFR Sections 410.2, 410.43, and 410.110
- Pub. 100-07, chapter 2, sections 2250 – 2252P

See sections 10.2.1(A)(3)(a) through 10.2.1(A)(3)(b) of this chapter for additional information on CMHC site visits.

3. Initial Enrollment and Certification

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

Effective October 29, 2014, CMHCs will be required to meet the conditions of participation outlined in 42 CFR Part 485, subpart J. CMHCs, like many other types of certified providers and certified suppliers, will therefore be required to undergo a State survey as part of the certification and enrollment process. The RO will no longer be performing the site visit discussed in section (B)(1) nor will the above-referenced attestation statement be required. Except as otherwise noted in this chapter 10 or in another CMS directive, CMHC initial applications shall – on and after October 29, 2014 - be processed in the same manner as those for all other certified providers.

b. Site Visit - Initials Post Tie In

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

i. Practice Locations/Alternative Sites

A CMHC must list in Section 4 of its Form CMS-855A all alternative sites where core services are provided (i.e., proposed alternative sites for initial applicants and actual alternative sites for those CMHCs already participating in Medicare). The RO will decide whether the site in question: (1) can be part of the CMHC's enrollment (i.e., a practice location), or (2) should be enrolled as a separate CMHC with a separate provider agreement. The practice location could be out-of-state if the RO determines that the location services the same “defined

geographic area” as the main location. In all cases, the RO makes the final determination as to whether a particular practice location qualifies as an alternative site or whether a separate enrollment, provider agreement, etc., is required. If the contractor is unsure as to whether the location requires a separate enrollment and provider agreement, it may contact the RO for clarification.

If a CMHC is (1) adding a new location or (2) changing the physical location of an existing location, the contractor shall order a site visit of the new/changed location through PECOS after the contractor receives notice of approval from the RO but before the contractor switches the provider’s enrollment record to “Approved.” This is to ensure that the new/changed location is in compliance with CMS’s enrollment requirements. The scope of the site visit will be consistent with Section 10.6.20(A) and 10.6.20(B) of this chapter. The NSVC will perform the site visit. The contractor shall not switch the provider’s enrollment record to “Approved” prior to the completion of the NSVC’s site visit and the contractor’s review of the results.

The contractor may refer to Pub. 100-07, SOM, chapter 2, section 2252, for additional information on CMHC alternative sites. Particular attention should be paid to the following provisions in section 2252I, regarding alternative sites:

- If a CMHC operates a CMS-approved alternative site, the site is not required to provide all of the core services. However, a patient must be able to access and receive the services he/she needs at the approved primary site, or at an alternative site that is within the distinct and definable community served by the CMHC.
- RO approvals of such alternative sites should be very limited because (1) CMHCs must serve a distinct and definable community, and (2) CMS has not limited the number of CMHCs an entity may submit for Medicare approval as long as these proposed CMHCs serve different communities.
- The RO will inform the CMHC if it determines that the proposed alternative site must be separately approved because it is not a part of the community where the CMHC is located.

ii. Changes of Information that Require Site Visits

If the CMHC submits a Form CMS-855A change application, the contractor shall order a site visit through PECOS for changes of address after the contractor receives notice of approval from the RO but before the contractor switches the provider’s enrollment record to “Approved.” This is to ensure that the provider is still in compliance with CMS’s enrollment requirements. The scope of the site visit will be consistent with Section 10.6.20(A) and 10.6.20(B) of this chapter. The NSVC will perform the site visit. The contractor shall not make a final decision regarding the change of information application prior to the completion of the NSVC’s site visit and the contractor’s review of the results.

iii. Revalidation Site Visits

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

4. CMHC 40 Percent Rule

a. Background

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

Pursuant to this requirement, a CMHC is required to submit to CMS a certification statement provided by an independent entity (such as an accounting technician). The document must certify that:

The entity has reviewed the CMHC's client care data for:

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

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

When processing, the contractor shall abide by the following:

i. Contractor Does Not Receive the Certification

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

ii. Contractor Receives the Certification

If the contractor receives the certification with the Form CMS-855 or timely receives the certification as part of a development request - The contractor shall review the certification to ensure that it complies with § 485.918(b)(1) and the provisions of this section 10.2.1(A). If the certification is compliant, the contractor shall continue processing the

application; if the certification is not compliant, the contractor shall deny the application or, if it chooses, develop for a revised certification.

Sections (B)(1) and (2) above do not apply if the contractor determines that the Form CMS-855 can be returned under Section 10.4(H)(1) of this chapter.

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

iii. Special Guidelines

The following guidelines apply:

An appropriate official of the certifying entity must sign the document. (Notarization is not required unless CMS requests it.) Such persons may include accounting technicians, CEOs, officers, directors, etc.

The certification should be on the certifying entity's letterhead or should otherwise indicate that the document is clearly from the entity.

The contractor shall include the certification in the recommendation package it sends to the state agency.

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

B. Comprehensive Outpatient Rehabilitation Facilities (CORFs)

1. General Background Information

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

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

(* Services that the CORF must provide)

In addition:

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

2. Enrollment Information

a. Offsite Locations

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

b. Site Visits

- i. Initial application – If a CORF submits an initial application, the contractor shall order a site visit through the Provider Enrollment, Chain and Ownership System (PECOS) after the contractor receives the tie-in notice (or approval letter) from the RO but before the contractor conveys Medicare billing privileges to the CMHC. This is to ensure that the provider is still in compliance with CMS’s enrollment requirements. The scope of the site visit will be consistent with Section 10.6.20(A) and 10.6.20(B) of this chapter. The National Site Visit Contractor (NSVC) will perform the site visit. The contractor shall not convey Medicare billing privileges to the provider prior to the completion of the NSVC’s site visit and the contractor’s review of the results.
- ii. Revalidation – If a CORF submits a revalidation application, the contractor shall order a site visit through PECOS. This is to ensure that the provider is still in compliance with CMS’s enrollment requirements. The scope of the site visit will be consistent with Section 10.6.20(A) and 10.6.20(B) of this chapter. The NSVC will perform the site visit. The contractor shall not make a final decision regarding the revalidation application prior to the completion of the NSVC’s site visit and the contractor’s review of the results.

iii. New/changed location - If a CORF is (1) adding a new location or (2) changing the physical location of an existing location, the contractor shall order a site visit of the new/changed location through PECOS after the contractor receives notice of approval from the RO but before the contractor switches the provider's enrollment record to "Approved." This is to ensure that the new/changed location is in compliance with CMS's enrollment requirements. The scope of the site visit will be consistent with Section 10.6.20(A) and 10.6.20(B) of this chapter. The NSVC will perform the site visit. The contractor shall not make a final decision regarding the change of information application prior to the completion of the NSVC's site visit and the contractor's review of the results.

3. Additional Information

For more information on CORFs, refer to:

- Section 1861(cc) of the Social Security Act
- 42 CFR Part 485, Subpart B
- Pub. 100-07, chapter 2, sections 2360 – 2366 (SOM)
- Pub. 100-07, chapter 3, section 3224 (SOM)
- Pub. 100-07, Appendix K (SOM)
- Pub. 100-02, chapter 12 (Benefit Policy Manual)

C. End-Stage Renal Disease Facilities (ESRDs)

1. General Background Information

ESRD facilities are entities that perform renal services for patients with irreversible and permanent kidney failure.

As ESRD facilities are technically "suppliers," they sign a supplier agreement rather than a provider agreement. Even if the ESRD facility is a hospital unit, it signs an agreement that is separate and distinct from the hospital's agreement.

ESRDs entities/facilities cannot be mobile.

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

The ESRD Network is a group of organizations under contract with CMS that serve as liaisons between the agency and ESRD providers. (There are currently 18 Network organizations.) The organizations oversee the care that ESRD patients receive, collect data, and furnish technical assistance to ESRD providers and patients.

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

- Section §1881 of the Social Security Act
- 42 CFR Part 405, Subpart U

- Pub. 100-07, State Operations Manual, chapter 2, section 2270 – 2287B
- Pub. 100-02, Benefit Policy Manual, chapter 11
- Pub. 100-04, Claims Processing Manual, chapter 8

3. Types of ESRD Facilities

There are several types of ESRD facilities:

a. Renal Transplantation Center (RTC)

An RTC is a hospital unit approved to furnish – directly - transplantation and other medical and surgical specialty services required for the care of ESRD transplant patients, including inpatient dialysis furnished directly or under arrangement. An RTC must be a member of the Organ Procurement and Transplantation Network (OPTN).

b. Renal Dialysis Center (RDC)

An RDC is a hospital unit approved to furnish the full spectrum of diagnostic, therapeutic, and rehabilitative services required for the care of ESRD dialysis patients (including inpatient dialysis furnished directly or under arrangement and outpatient dialysis). Also:

- The RDC need not furnish transplantation services.
- An RTC can also be an RDC.
- The RDC must be hospital-owned and operated, and the hospital must be enrolled in Medicare.

A separate, independent dialysis unit located in a Medicare-approved hospital cannot be approved as an RTC or RDC. (See Pub. 100-07, State Operations Manual, chapter 2, section 2280.1.)

c. Renal Dialysis Facility (RDF)

This is a unit (but not necessarily a hospital unit) approved to furnish dialysis services directly to ESRD patients. A hospital (whether enrolled or not) can be an RDF if it is an outpatient provider of dialysis services that will not be furnishing inpatient dialysis services. A hospital-based RDF “satellite” is one that is hospital-owned and administered but is not located on the hospital’s premises. A hospital can have multiple RDF satellites.

d. Self-Dialysis Unit (SDU)

An SDU is a unit of an approved RTC, RDC or RDF that provides self-dialysis services.

e. Special Purpose Renal Dialysis Facility (SPRDF)

SPRDFs are entities that perform ESRD services on a short-term basis in special situations for patients who cannot otherwise receive treatment in

the geographical area. SPRDFs can be approved to serve vacation areas and in emergency situations. (See Pub. 100-07, State Operations Manual, chapter 2, section 2280D for more information on SPRDFs.) Like RTCs, RDCs, RDFs, and SDUs, SPRDFs must submit a Form CMS-855A to the contractor.

4. ESRD Enrollment

Each type of ESRD facility must enroll as an ESRD facility via the Form CMS-855A. Since the Form CMS-855A does not distinguish between the different types of ESRD facilities, the following principles apply:

- a. If an enrolled RTC also wants to become an RDC, the provider must submit a new, complete Form CMS-855A for the RDC. For enrollment purposes, the RTC and the RDC will be treated as two separate ESRD facilities.
- b. If an enrolled ESRD wants to change to another type of ESRD, the provider need not submit a Form CMS-855A change of information (assuming that this is the only change to the provider's enrollment data).
- c. ESRD facilities can have multiple practice locations if the RO approves it, though this typically only occurs with RDFs.

5. ESRD Survey and Certification

The standard CMS survey and certification form used for ESRDs is the Form CMS-3427. Part I of this form must be completed, as must the Form CMS-855A, when the ESRD is initially enrolling, changing or adding a location, or undergoing a change of ownership (CHOW). Part I must also be completed for: (1) a change in service and (2) an expansion or addition of ESRD stations. However, the Form CMS-855A need not be furnished in these two latter instances (e.g., an ESRD station does not qualify as a practice location on the Form CMS-855A), though the RO may issue a tie-in notice or approval letter to the contractor as notification of the change. Also, because the "End-Stage Renal Disease Facility" category on the Form CMS-855A encompasses all five ESRD categories, it is not necessary for the facility to submit a Form CMS-855A if it is changing from one ESRD type to another, though it must complete the Form CMS-3427. (See Pub. 100-07, State Operations Manual, chapter 2, sections 2274 – 2276 and 2278 – 227, for more information on the Form CMS-3427 requirement.)

If the RO approves the station/service change or addition, it may send a tie-in notice or approval letter to the contractor updating the number of stations or types of services.

6. Site Visits

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

D. Federally Qualified Health Centers (FQHCs)

Section 4161(a)(2) of OBRA '90 (P.L. 101-508) amended §1861(aa) of the Act and established FQHC services as a benefit under the Medicare program effective October 1,

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

1. General Background Information

To participate in the Medicare program, applicants seeking initial enrollment as an FQHC must submit a Form CMS-855A application to the appropriate MAC.

FQHCs furnish services such as those performed by physicians, nurse practitioners, physician assistants, clinical psychologists, and clinical social workers. This also includes certain preventive services like prenatal services, immunizations, blood pressure checks, hearing screenings and cholesterol screenings. (See CMS Publication 100-02, chapter 13, for more information). Even though they complete the Form CMS-855A application, FQHCs are considered Part B certified suppliers. FQHCs are not required to obtain a State survey; there is no State agency involvement with FQHCs.

The Federally Qualified Health Centers (FQHCs) are considered “suppliers” under Part B of Medicare and are paid Part B benefits for FQHC services. For the purpose of Medicare enrollment, an FQHC is defined as an entity that has entered into an agreement with CMS to meet Medicare program requirements under 42 CFR 405.2434(a), and:

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

As such, the contractor will either approve the application and inform PEOG of the decision or deny the application. PEOG will issue the FQHC’s CCN to the contractor. Generally, in order to so qualify, the facility must be receiving, or be eligible to receive, the following types of Federal grants listed above.

The Health Resources and Services Administration (HRSA) of the United States Department of Health and Human Services (DHHS) may assist the contractor in determining whether a particular supplier meets FQHC standards, since HRSA maintains a list of suppliers that met certain grant requirements (see CMS Pub. 100-07, chapter 2, sections 2825-2826D for more information).

2. Reviewing Initial FQHC Applications:

The following documents must be included in the application:

- *A signed and completed application Form CMS-855A enrollment application;*
- *Two signed and dated copies of the attestation statement (Exhibit 177). In order to attest to being in compliance, the facility must be open and operating when the attestation is signed. Since FQHCs must sign an agreement stipulating that they will comply with §1861(aa)(4) of the Act and specific FQHC regulations, this statement serves as the Medicare FQHC agreement when it is also signed and dated by CMS PEOG.*
- *HRSA Notice of Grant Award or FQHC Look-Alike Designation that includes an address for the site of the applicant which matches the practice location reported on the Form 855A (Note: FQHCs should submit the second Notice of Award the provider has received from The Health Resources and Services Administration (HRSA) which states that the provider is open and operational);*
- *Form CMS-588 Electronic Funds Transfer (EFT) Authorization Agreement;*
- *Clinical Laboratory Improvement Act (CLIA) Certificate (if applicable). Facilities that examine human specimens for the diagnosis, prevention, or treatment of any disease or impairment of, or the assessment of the health of, human beings is considered a laboratory and must meet CLIA requirements. These facilities must apply and obtain a certificate from the CLIA program that corresponds to the complexity of tests performed. Certain types of laboratories and laboratory tests are NOT subject to meeting CLIA requirements. One example would be facilities which serve only as collection stations. A collection station receives specimens to be forwarded to a laboratory performing diagnostics test. Chapter 6, Section 6002 of the State Operations Manual provides additional details regarding laboratories and laboratory tests NOT subject to CLIA requirements. It is the responsibility of the FQHC applicant to review the CLIA requirements and obtain a CLIA certificate if needed. The MAC, nor CMS does not make a determination as to whether the FQHC applicant must obtain and submit a CLIA certificate; and*
- *Copy of State License (if applicable).*

When *reviewing* an initial FQHC application, the contractor shall *verify* the date on which the FQHC's application was complete. To illustrate, assume that the FQHC submitted an initial application on March 1. Two data elements were missing; the contractor thus requested additional information. The two elements were submitted on March 30. The contractor shall therefore indicate the March 30 date in its *approval* letter as the *effective date of the FQHC*. Additionally, the contractor shall ensure the date that the *Attestation Statement for Federally Qualified Health Centers Exhibit 177 was signed on or after the date the FQHC includes as their effective date*. The application should be denied if the *Exhibit 177 was signed prior to the*

effective date listed in the application, as the FQHC should be providing services in order to meet the regulations noted in the Exhibit 177.

3. PEOG Referrals of FQHC Applications:

Contractors shall contact the Provider Enrollment & Oversight Group (PEOG) via email once the determination has been made that the initial FQHC's application is to be approved. The contractor shall provide a copy of the draft approval letter, CMS-855A application or PECOS Application Data Report (ADR) and all supporting documentation, copy of the FQHC's HRSA documentation and the Exhibit 177 to PEOG. After receipt, PEOG will respond with the new FQHC's CMS Certification Number and the signed Agreement (to be provided to the FQHC in the contractor's approval letter).

4. Additional information about FQHCs:

- a. As stated above, there is no State agency involvement with FQHCs. However, FQHCs still must meet all applicable State and local requirements and submit all applicable licenses. Typically, HRSA will verify such State/local compliance by asking the FQHC to attest that it meets all State/local laws.
- b. FQHCs can be based in a rural or urban area that is designated as either a shortage area or an area that has a medically underserved population.
- c. To qualify as an FQHC, the facility must, among other things, either (1) furnish services to a medically underserved population or (2) be located in a medically underserved area.
- d. The FQHC must submit a signed and dated Attestation Statement for Federally Qualified Health Centers (Exhibit 177). This attestation serves as the Medicare FQHC benefit (or provider/supplier) agreement. (See Pub. 100-07, chapter 2, section 2826B.) The FQHC must also submit, as indicated above, a HRSA "Notice of Grant Award" or Look-Alike Status. A completed FQHC crucial data extract sheet (Exhibit 178), however, is no longer required.
- e. The contractor shall ensure that the attestation statement (Exhibit 177) contains the same legal business name and address as that which the FQHC provided in section 2 and section 4, respectively, of the Form CMS-855A. If the attestation contains a different name, the contractor shall develop for the correct name.
- f. An FQHC cannot have multiple sites or practice locations. Each location must be separately enrolled and will receive its own CMS Certification Number.

5. Site Visits

Site visits for FQHCs are performed by the Health Resources and Services Administration (HRSA) prior to enrollment.

6. Location Changes

If the FQHC is changing its physical location of an existing location, the FQHC must submit the Notice of Grant Award form from HRSA approving the physical location change. The contractor shall review HRSA's Data Warehouse, <https://data.hrsa.gov/tools/shortage-area>, to determine whether the location falls within a shortage area. Once determined that the FQHC resides in a shortage area, the contractor shall process the change of information application after confirming that the new location remains in a shortage area or an area with a medically underserved population. Contractors should consult the appropriate CMS Location (formerly CMS Regional Offices (ROs)) regarding this determination prior to making a decision should any questions arise during processing.

If approving the location change, the contractor does not issue a recommendation of approval to the RO, the contractor shall approve the location change in PECOS and issue an approval letter to the FQHC. The contractor shall send the RO the approval letter of the change via email. No tie-in will be issued for an address change.

If the contractor does not approve of the location change, (if the FQHC was found to no longer reside in a shortage area or another reason for denial is discovered), the contractor shall deny the application stating that the provider no longer meets regulations as an FQHC and the FQHC's enrollment shall be deactivated on the date the change of locations noted in the application.

7. Complaint Investigations

CMS Locations investigate complaints which raise credible allegations of noncompliance by an FQHC with Medicare requirements and health and safety standards found at 42 CFR 405 Subpart X, and 42 CFR 491 Subpart A, except for 42 CFR 491.3. MACs should refer such complaints to the CMS Location in which the FQHC is located.

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

- Section 1861(aa)(3-4) of the Social Security Act
- 42 CFR Part 491 and 42 CFR Part 405.2400
- Pub. 100-07, chapter 2, sections 2825 – 2826H
- Pub. 100-07, Exhibit 179
- Pub. 100-04, chapter 9 (Claims Processing Manual)
- Pub. 100-02, chapter 13 (Benefit Policy Manual)

For information on the appropriate contractor jurisdictions for incoming FQHC enrollment applications, see:

- Pub. 100-04, chapter 1, section 20
- Pub. 100-04, chapter 9, section 10.3

E. Histocompatibility Laboratories

1. General Background Information

A histocompatibility laboratory does “matching” tests in preparation for procedures such as kidney transplants, bone marrow transplants, and blood platelet transfusions. It is the only type of laboratory that must submit a

Form CMS-855A application. Each histocompatibility lab must meet all applicable requirements in 42 CFR Part 493¹ (see 42 CFR §493.1 in particular) and undergo a State survey.

2. Additional Information

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

F. Home Health Agencies (HHAs)

1. General Background Information

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

Like most certified providers, HHAs receive a State survey (or a survey from an approved accrediting organization to determine compliance with Federal, State, and local laws), and must sign a provider agreement. All HHA services, moreover, must be part of a plan of care established by a physician, accompanied by a certification from the physician that the patient needs home health services. HHA services can be covered even if the patient lives with someone who might ordinarily be able to perform such services himself/herself.

2. Site Visit Requirements

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

3. HHA Components

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

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

Branch – A branch is a location or site that services patients in the same geographic area as the parent and shares administration with the parent on a daily basis. Branches need not enroll separately. They can be listed as practice locations on the main provider's Form CMS-855A. Though the branch receives a 10-digit CCN identifier, it bills under the parent HHA's CCN number.

See Pub. 100-07, chapter 2, section 2182, for more information on branches.

4. Out-of-State HHA Branches

¹ Clinical laboratory certification is handled by the Food and Drug Administration

In general, an HHA can only have a branch in another State (and treat it as a branch, rather than a separate HHA) if there is a reciprocity agreement between the two States. If none exists, the out-of-state location must enroll as a new provider by submitting a new Form CMS-855A and signing a separate provider agreement. It cannot be treated as a branch/practice location of the main HHA. (See Pub. 100-07, chapter 2, section 2184 for specific provisions regarding HHAs that cross State lines.)

5. Home Health Agency (HHA) Branches

As explained in section 10.2.1(F)(3), a branch is a location or site from which an HHA provides services within a portion of the total geographic area that the parent company serves. The branch is part of the HHA and is located sufficiently close to the parent agency such that it shares administration, supervision, and services with the parent. If an existing HHA wants to add a branch, it is considered a change of information on the Form CMS-855A.

If the contractor makes a recommendation for approval of the provider's request to add an HHA branch, the contractor shall forward the package to the State agency as described in this chapter. However, the contractor shall emphasize to the provider that a recommendation for approval of the branch addition does not signify CMS's approval of the new location. Only the RO can approve the addition.

With respect to the PECOS, the contractor does not need to create a separate enrollment record for each HHA branch. These locations can simply be listed on the main provider's enrollment record.

6. Verification of HHA Sites

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

7. Nursing Registries

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

8. HHA Ownership Changes

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.

a. Exceptions

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

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

b. Applicability

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, then 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).

c. Section 424.550(b)(1)'s Applicability (36-Month Rule)

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

Step 1 – Change in Majority Ownership

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

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

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

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

Step 2 – 36-Month Period

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

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

Step 3 – Applicability of Exceptions

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

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

A. For purposes of this exception, low utilization or no utilization cost reports do not qualify as full cost reports. 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.

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

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

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

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

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

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

d. 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 state 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. The effective date of the deactivation shall be the date the HHA is notified that it must enroll as an initial applicant. If the sale has not occurred, the contractor shall alert the HHA that it must submit a Form CMS-855A voluntary termination application.

Providers and/or their representatives (e.g., attorneys, consultants) shall contact their local MAC with any questions concerning (1) the 36-month

rule in general and (2) whether the rule and/or its exceptions apply in a particular provider's case.

e. Additional Notes

The contractor is advised of the following:

- i. If the contractor learns of an HHA ownership change by means other than the submission of a CMS-855A application, it shall notify its PEOG BFL immediately.
- ii. If the contractor determines, under Step 3 above, that one of the §424.550(b)(2) exceptions applies, the ownership transfer still qualifies as a change in majority ownership for purposes of the 36-month clock. To illustrate, assume that an HHA initially enrolled in Medicare effective July 1, 2010. It 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).

9. Capitalization

a. Background

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

b. Points of Review

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

- Prior to making its recommendation for approval;
- After a recommendation for approval is made but before the RO review process is completed;
- After the RO review process is completed but before the contractor conveys Medicare billing privileges to the HHA; and

- During the 3-month period after the contractor conveys Medicare billing privileges to the HHA.

For initial applications, the contractor shall verify that the HHA meets all of the capitalization requirements addressed in 42 CFR §489.28. (Note that capitalization need not be reviewed for revalidation or reactivation applications.) The contractor may request from the provider any and all documentation deemed necessary to perform this task.

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

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

c. Determining Initial Reserve Operating Funds

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

The contractor shall determine the amount of the initial reserve operating funds using reported cost and visit data from submitted cost reports for the first full year of operation from at least 3 HHAs that the contractor serves that are comparable to the HHA that is seeking to enter the Medicare program. Factors to be used in making this determination shall include:

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

The determination of the adequacy of the required initial reserve operating funds is based on the average cost per visit of the comparable HHAs, by dividing the sum of total reported costs of the HHAs in their first year of operation by the sum of the HHAs' total reported visits. The resulting average cost per visit is then multiplied by the projected visits for the first 3 months of operation of the HHA seeking to enter the program, but not less than 90 percent of average visits for a 3-month period for the HHAs used in determining the average cost per visit.

d. Proof of Operating Funds

The HHA must provide CMS with adequate proof of the availability of initial reserve operating funds. Such proof, at a minimum, must include a copy of the statement(s) of the HHA's savings, checking, or other account(s) that contains the funds, accompanied by an attestation from an officer of the bank or other financial institution that the funds are in the account(s) and that the funds are immediately available to the HHA.

In some cases, an HHA may have all or part of the initial reserve operating funds in cash equivalents. For the purpose of this section, cash equivalents are short-term, highly liquid investments that are readily convertible to known amounts of cash and that present insignificant risk of changes in value. A cash equivalent that is not readily convertible to a known amount of cash as needed during the initial 3-month period for which the initial reserve operating funds are required does not qualify in meeting the initial reserve operating funds requirement. Examples of cash equivalents for the purpose of this section are Treasury bills, commercial paper, and money market funds.

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

e. Borrowed Funds

If borrowed funds are not in the same account(s) as the HHA's own non-borrowed funds, the HHA also must provide proof that the borrowed funds are available for use in operating the HHA, by providing, at a minimum, a copy of the statement(s) of the HHA's savings, checking, or other account(s) containing the borrowed funds, accompanied by an attestation from an officer of the bank or other financial institution that the funds are in the account(s) and are immediately available to the HHA. As with the HHA's own (that is, non-borrowed) funds, CMS later may require the HHA to establish the current availability of such borrowed funds, including furnishing an attestation from a financial institution or other source, as may be appropriate, and to establish that such funds will remain available until a date when the HHA will have been surveyed by the State agency or by an approved accrediting organization.

f. Line of Credit

If the HHA chooses to support the availability of a portion of the initial reserve operating funds with a line of credit, it must provide CMS with a letter of credit from the lender. CMS later may require the HHA to

furnish an attestation from the lender that the HHA, upon its certification into the Medicare program, continues to be approved to borrow the amount specified in the letter of credit.

g. Documents

- As part of ensuring the prospective HHA's compliance with the capitalization requirements, the contractor shall obtain the following from the provider:
- A document outlining the provider's projected budget – preferably, a full year's budget broken out by month
- A document outlining the number of anticipated visits - preferably a full year broken out by month
- An attestation statement from an officer of the HHA defining the source of funds
- Copies of bank statements, certificates of deposits, etc., supporting that cash is available (must be current)
- Letter from officer of the bank attesting that funds are available
- If available, audited financial statements

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

10. Additional Home Health Agency (HHA) Review Activities:

As stated in section 10.2.1(F)(9) of this chapter, the contractor must verify that a newly enrolling HHA has the required amount of capitalization after the regional office (RO) review process is completed but before the contractor conveys Medicare billing privileges to the HHA. Accordingly, the HHA must submit proof of capitalization during this “post-RO review” period.

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

The capitalization and MED/SAM re-reviews described above shall be performed once the RO notifies the contractor via e-mail that the RO's review is complete. (Per sections 10.2.1(F)(6) and *10.6.20(A) and 10.6.20(B) of this chapter*, a site visit will be performed after the contractor receives the tie-in/approval notice from the RO but before the contractor conveys Medicare billing privileges to the HHA.) If:

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

- i. The contractor shall notify the RO of this via e-mail. The notice shall specify the date on which the contractor completed the aforementioned reviews.
- ii. The RO will: (1) issue a CMS Certification Number (CCN), (2) sign a provider agreement, and (3) send a tie-in notice or approval letter to the contractor. Per *Section 10.6.1(B) of this chapter*, the contractor shall complete its processing of the tie-in notice/approval letter within 45 calendar days of receipt (during which time a site visit will be performed).
- iii. Upon receipt of RO's notification, contractor will perform capitalization reviews discussed in section 10.2.1(F)(9) and OIG/SAM reviews discussed in Section 10.2.1(F)(10) of this chapter.

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

- i. The contractor shall deny the application in accordance with the instructions in this chapter and issue appeal rights. (The denial date shall be the date on which the contractor completed its follow-up capitalization and OIG/SAM reviews.)
- ii. Notify the RO of the denial via e-mail. (PEOG, not the RO, will handle any CAP or appeal related to the contractor's denial.)
- iii. Upon receipt of RO's notification, contractor will perform capitalization reviews discussed in section 10.2.1(F)(9) and OIG/SAM reviews discussed in section 10.2.1(F)(10) of this chapter.

11. Recommendation Before New HHA Location Established

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

12. Additional Information

For more information on HHAs, refer to:

- Sections 1861(o) and 1891 of the Social Security Act
- 42 CFR Part 484
- 42 CFR § 489.28 (capitalization)
- Pub. 100-07, chapter 2, sections 2180 – 2198C (State Operations Manual)
- Pub. 100-04, chapter 10 (Claims Processing Manual)
- Pub. 100-02, chapter 7 (Benefit Policy Manual)

G. Hospices

1. General Background Information

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

2. Enrollment Information

a. Multiple Practice locations

Hospices are not precluded from having multiple practice locations if permitted by the regional office (RO). If the RO disapproves an additional practice location, the location must seek Medicare approval as a separate hospice with its own enrollment and provider agreement. (See Pub. 100-07, State Operations Manual (SOM), chapter 2, section 2081, for the policies regarding multiple hospice locations.)

b. Site Visits

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

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

iii. New/changed location - If a hospice is (1) adding a new location or (2) changing the physical location of an existing location, the contractor shall order a site visit of the new/changed location through PECOS after the contractor receives notice of approval from the RO but before the contractor switches the provider’s enrollment record to “Approved.” This is to ensure that the new/changed location is in compliance with CMS’s enrollment requirements. The scope of the site visit will be consistent with *Section 10.6.20(A) and 10.6.20(B) of this chapter*. The NSVC will perform the site visit. The contractor shall not switch the

provider's enrollment record to "Approved" prior to the completion of the NSVC's site visit and the contractor's review of the results.

3. Additional Information:

For more information on hospices, refer to:

- Sections 1861(u) and 1861(dd) of the Social Security Act
- 42 CFR Part 418
- Pub. 100-07, chapter 2, sections 2080 – 2087 (SOM)
- Pub. 100-04, chapter 11 (Claims Processing Manual)
- Pub. 100-02, chapter 9 (Benefit Policy Manual)

H. Hospitals and Hospital Units

1. General Background Information

Hospitals and hospital units are a provider type that enrolls via the form CMS-855A, except when the hospital is requesting enrollment to bill for practitioner services for hospital departments, outpatient departments, outpatient locations, and/or hospital clinics. In this circumstance:

- A new enrollment application is required
- Enrollment Form CMS-855B is the required application form

2. Enrollment Information

a. Swing-Bed Designation

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

As stated in 42 CFR §482.66, in order to obtain swing-bed status the hospital – among other things – must: (1) have a Medicare provider agreement, (2) be located in a rural area, and (3) have fewer than 100 non-newborn or intensive care beds. Swing-bed hospitals, therefore, are generally small hospitals in rural areas where there may not be enough SNFs. The hospital is thus used to furnish SNF services.

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

Additional data on "swing-bed" units can be found in Pub. 100-07, State Operations Manual, chapter 7, sections 2036 – 2040.

b. Psychiatric and Rehabilitation Units

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

c. Multi-Campus Hospitals

A multi-campus hospital (MCH) has two or more hospital campuses operating under one CCN number. The MCH would report its various units/campuses as practice locations on the Form CMS-855A. A hospital that has its own main campus but also occupies space in another hospital has a "satellite facility" in that other hospital.

For additional information on multi-campus hospitals, see Pub. 100-07, chapter 2, section 2024.

d. Physician-Owned Hospitals

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

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

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

e. Critical Access Hospitals

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

f. Hospital Addition of Practice Location

In situations where a hospital is adding a practice location, the contractor shall notify the provider in writing that its recommendation for approval

does not constitute approval of the facility or group as provider-based under 42 CFR § 413.65.

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

g. Transplant Centers

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

3. Other Enrollment Procedures

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

If an enrolled hospital seeks to add a rehabilitation, psychiatric, or swing-bed unit, it should submit a Form CMS-855 change of information request and not an initial enrollment application. With respect to the Provider Enrollment, Chain and Ownership System, the contractor shall create a separate enrollment record for the hospital unit.

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

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

5. Form CMS-855B Applications Submitted by Hospitals

a. Group Practices

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

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

b. Individual Billings

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

I. Indian Health Services (IHS) Facilities

1. General Background Information

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

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

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

2. Enrollment Information

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

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

Novitas Solutions, Inc.
P.O. Box 3115
Mechanicsburg, PA 17055-1858

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

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

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

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

Pursuant to this statutory provision, any physician or practitioner need only be licensed in one State – regardless of whether that State is the one in which the practitioner practices – if he or she is employed by a tribal health program performing services as permitted under the ISDEAA (see CMS Pub. 100-04, chapter 19, section 10 for definitions).

The contractor shall apply this policy when processing applications from these individuals. In terms of the effective date of Medicare billing privileges, the contractor shall continue to apply the provisions of 42 CFR § 424.520(d) and sections 10.2.3(A) through 10.2.3(N) of this chapter.

4. Additional Information

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

J. Organ Procurement Organizations (OPOs)

1. General Background Information

An OPO is an organization that performs or coordinates the procurement, preservation, and transport of organs, and maintains a system for locating prospective recipients for available organs. There are three general steps involved in becoming a Medicare OPO: enrollment, certification and designation.

Certification means that CMS has determined that an OPO meets the requirements for certification at 42 CFR §486.303. It does not mean, however, that the OPO can begin billing for services. CMS must first assign

(or “designate”) a geographic service area to the OPO. (The provider must also complete the Form CMS-576, Request for OPO Designation.) In practical terms, “designation” means that CMS has approved the OPO for coverage of services to transplant centers and that the OPO can begin submitting claims to Medicare.

There can be only one designated OPO per geographic service area. When an OPO is de-certified and its service area is opened for competition, the applicable CMS regional office publishes a notice in local newspapers. CMS then selects an OPO to take over the service area, using the process at 42 CFR §486.316. The OPO that CMS selects must first have been certified by CMS and must meet the qualifications for designation at 42 CFR §486.304. The OPO must also sign a provider agreement (Form CMS-576A) and participate in the Organ Procurement and Transplantation Network. (See CMS Pub. 100-07, chapter 2, sections 2810 and 2811.) Note that OPOs do not receive a State survey.

2. Additional Information

For more information on OPOs, refer to:

- Section 1138 of the Social Security Act
- 42 CFR §486.301 - §486.348
- Pub. 100-07, chapter 2, sections 2810 – 2819 (State Operations Manual).

For guidance on the appropriate contractor jurisdiction for incoming OPO applications, see CMS Pub. 100-04, chapter 1, section 20. Note that a hospital-based OPO must enroll separately, be separately certified, and sign its own provider agreement. However, the hospital’s Medicare contractor will service the OPO, and the OPO will not receive its own CMS Certification Number.

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

1. General Background Information

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

2. Enrollment Information

a. Providers of OPT/OSP Services

There are three types of certified providers of OPT/OSP services:

- **Rehabilitation Agencies** – These facilities furnish services in a team environment and in accordance with a “multidisciplinary” program to assist handicapped and disabled individuals. They provide not only OPT/OSP services, but social or vocational adjustment services as

well. (See CMS Pub. 100-07, chapter 2, section 2292A.) The overwhelming majority of Part A OPT/OSP providers are rehabilitation agencies.

- **Clinics** – A clinic is created primarily for the provision of outpatient physician services. The entity's services must be furnished by a group of at least three physicians practicing medicine together, and at least one physician must be present in the clinic at all times to perform medical services.
- **Public Health Agency** – This is an agency created by a State or local government. Its primary purpose is to furnish environmental health services, preventive medical services and, in some instances, therapeutic services, as a means of sustaining the health of the general population.

Note that:

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

b. Extension Locations

As discussed in Pub. 100-07, chapter 2, section 2298A, an OPT/OSP provider can furnish services from locations other than its primary site. (The provider must designate one location as its primary location, however.) These sites are called extension locations. They may include freestanding offices, suites in an office or medical building, or even space in an existing Medicare provider, such as a skilled nursing facility or hospital. Yet the separate area of the host provider or facility must be set aside for the provision of OPT/OSP services during the hours of the OPT/OSP provider's operations. (The area/room/unit would be considered the extension location.)

An OPT/OSP provider may also furnish therapy services in a patient's home or in a patient's room in a SNF. Because they are not considered extension locations, neither the home nor the patient's room need be listed as a practice location on the provider's Form CMS-855A. (See Pub. 100-07, chapter 2, section 2298B.)

For an OPT/OSP provider to establish an extension location in an adjoining State, the two States involved must have a signed reciprocity

agreement with each other allowing approval of the extension location. An extension location situated in a different State will bill under the primary site's provider number. (See Pub. 100-07, chapter 2, section 2302.)

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

With respect to the Provider Enrollment, Chain and Ownership System, a separate enrollment record for each OPT/OSP extension site is not required. These locations can simply be listed on the main provider's enrollment record.

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

- Section 1861(p) of the Social Security Act
- 42 CFR Part 485, subpart H
- Pub. 100-07, chapter 2, sections 2290 – 2306 (State Operations Manual)
- Pub. 100-07, Appendix E

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

1. General Background Information

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

CMS's Boston regional office has primary responsibility over the approval and certification of RNCHIs. RNCHIs are not certified by the State, but must meet all of the conditions of coverage outlined in 42 CFR §403.720, as well as all conditions of participation outlined in 42 CFR §403.730 through 403.746. For purposes of provider enrollment, the three most important conditions are that the provider:

- a. Must not be owned by, under common ownership with, or have an ownership interest of 5 percent or more in, a provider of medical treatment or services.

b. Must not be affiliated with a provider of medical treatment or services or with an individual who has an ownership interest of 5 percent or more in a provider of medical treatment or services. (Permissible affiliations are described in 42 CFR §403.738(c)).

c. Must be a non-profit organization per subsection (c)(3) of §501 of the Internal Revenue Code of 1986, and exempt from taxes under subsection 501(a).

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

2. Additional Information

For more information on RNCHIs, refer to:

- Section 1861(ss)(1) of the Social Security Act
- 42 CFR Part 403, subpart G
- Pub. 100-07, chapter 2, sections 2054, 2054.1, 20541A and 2054.1 (State Operations Manual)
- Pub. 100-04, chapter 3, sections 170 - 180 (Claims Processing Manual)
- Pub. 100-02, chapter 1, sections 130 – 130.4.2 (Benefit Policy Manual)

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

M. Rural Health Clinics (RHCs)

1. General Background Information

Rural health clinics (RHCs):

- Are considered to be Part B certified suppliers, even though they enroll in Medicare via the Form CMS-855A.
- Must be primarily engaged in furnishing outpatient services. However, the services can, in certain instances, be performed in locations outside of the four walls of the clinic. (See CMS Pub. 100-02, chapter 13 for more information.)
- There are certain services performed by RHCs that do not actually qualify as RHC services. To bill for these services, the clinic must enroll as a Clinic/Group Practice via the Form CMS-855B. It is not uncommon to see RHCs simultaneously enrolled in Medicare via the Form CMS-855A (to bill for RHC services) and the Form CMS-855B (to bill for non-RHC services).
- Sign a supplier agreement with CMS (akin to those signed by certified providers). Specifically, RHCs sign the Health Insurance Benefit Agreement (Form CMS-1561A).

- Can be either mobile in nature or fixed/permanent locations.
- Note that a facility cannot be simultaneously enrolled as an FQHC and an RHC. Though there are similarities between these two supplier types, there are key differences as well:
 - Unlike FQHCs, which can service rural or urban regions, an RHC may only service an area that: (1) is rural, and (2) contains a shortage of health services or qualified medical personnel (otherwise known as a “shortage area”). (See Pub. 100-02, chapter 13, section 10, which states that RHCs are clinics located in areas that are designated by (1) the Bureau of the Census as rural, and (2) the Secretary of the Department of Health and Human Services or the State as medically underserved.)
 - FQHCs furnish preventive services. RHCs do not.
 - RHCs are surveyed by the State. FQHCs are not.

2. Additional Information

For more information on RHCs, refer to:

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

For guidance on the appropriate contractor jurisdictions for incoming RHC applications, refer to:

- Pub. 100-04, chapter 1, section 20
- Pub. 100-04, chapter 9, section 10.3

N. Skilled Nursing Facilities (SNFs)

1. General Background Information

As stated in CMS Pub. 100-07, State Operations Manual, chapter 7, section 7004B, a SNF is a facility that:

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

The transfer agreement mentioned above need not be submitted with the SNF's Form CMS-855A enrollment application; the State and/or CMS regional office (RO) will verify that the agreement exists.

Like other certified providers, SNFs receive a State survey and sign a provider agreement. SNFs cannot have multiple practice locations.

2. SNF Distinct Parts

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

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

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

3. Additional Information

For more information on SNFs, refer to:

- Section 1819 of the Social Security Act
- Pub. 100-07, State Operations Manual, chapter 7
- Pub. 100-02, Benefit Policy Manual, chapter 8

10.2.2 – Suppliers That Enroll Via the Form CMS-855B

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

A. Ambulatory Surgical Centers (ASCs)

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

1. General Background Information

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

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

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

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

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

2. Additional Enrollment Information

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

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

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

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

3. Ambulatory Surgical Centers (ASCs) and Reassignment

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

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

4. Ambulatory Surgical Centers (ASCs) - Initial Enrollment

Unlike other supplier types that enroll via the Form CMS-855B, ASCs must receive a State survey and RO approval before they can enroll in Medicare. Accordingly, once it finishes reviewing the supplier's application, the contractor may only make a recommendation for approval to the State. The contractor shall not enroll the supplier until it receives a tie-in notice or approval letter from the RO.

When enrolling the ASC, the contractor shall use the effective date that is indicated on the tie-in notice/approval letter. This is the date from which the supplier can bill for services. See *Section 10.6.1(B)(5) of this chapter* for more information on ASC tie-in notices/approval letters.

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

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

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

6. ASCs and CHOWs

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

7. Additional Information

For more information on ASCs, refer to:

- 42 CFR Part 416
- Pub. 100-07, State Operations Manual, chapter 2, section 2210 and Appendix L
- Pub. 100-02, Benefit Policy Manual, chapter 15, sections 260 – 260.5.3
- Pub. 100-04, Claims Processing Manual, chapter 14
- Also, see Pub. 100-07, State Operations Manual, chapter 2, section 2210, for information regarding the sharing of space between ASCs and other providers.

8. ASCs and Hospitals

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

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

B. CLIA Labs

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

1. General Background Information

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

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

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

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

assigned a CLIA identification number for Medicare and Medicaid payment purposes.

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

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

2. Certificates

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

3. CLIA Enrollment

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

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

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

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

5. Site Visits of Independent CLIA Labs

- a. Initial application – If an independent CLIA lab submits an initial application, the contractor shall order a site visit through the Provider Enrollment, Chain and Ownership System (PECOS). This is to ensure that the supplier is still in compliance with CMS’s enrollment requirements. The scope of the site visit will be consistent with *Section 10.6.20(A) and 10.6.20(B) of this chapter*. The National Site Visit Contractor (NSVC) will perform the site visit. The contractor shall not convey Medicare billing privileges to the supplier prior to the completion of the NSVC’s site visit and the contractor’s review of the results.

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

c. New/changed location - If an independent CLIA lab is (1) adding a new location or (2) changing the physical location of an existing location, the contractor shall order a site visit of the new/changed location through PECOS before the contractor switches the supplier’s enrollment record to “Approved.” This is to ensure that the new/changed location is in compliance with CMS’s enrollment requirements. The scope of the site visit will be consistent with *Section 10.6.20(A) and 10.6.20(B) of this chapter*. The NSVC will perform the site visit. The contractor shall not switch the supplier’s enrollment record to “Approved” prior to the completion of the NSVC’s site visit and the contractor’s review of the results.

6. Integrated CLIA Labs

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

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

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

7. Additional Information

For additional data on CLIA laboratories, refer to:

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

C. Mammography Screening Centers

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

1. General Background Information

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

2. Enrollment of Mammography Screening Centers

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

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

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

D. Pharmacies

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

1. General Background Information

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

2. Additional Information

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

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

E. Portable X-Ray Suppliers (PXRSs)

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

1. General Background Information

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

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

A PXRS does not have a supplier agreement.

2. Enrollment of PXRSs

a. Initial application

Unlike other supplier types that enroll via the Form CMS-855B, PXRSs must receive a State survey and RO approval before they can enroll in Medicare. Accordingly, once it finishes reviewing the supplier's application, the contractor may only make a recommendation for approval to the State. The contractor shall not enroll the supplier until it receives a tie-in notice or approval letter from the RO and a follow-up site visit is performed per section 10.2.2(E)(3) of this chapter.

When enrolling the PXRS, the contractor shall use the effective date that is indicated on the tie-in notice/approval letter. This is the date from which the supplier can bill for services. See *Section 10.6.1(B)(5) of this chapter* for more information on PXRS tie-in notices/approval letters.

b. Practice Location Information

- In order to enroll as a PXRS, a supplier must complete a Form CMS-855B, undergo a State survey, and obtain RO approval. In Section 4 of the Form CMS-855B, the PXRS must furnish certain information, including:
 - Whether it furnishes services from a “mobile facility” or “portable unit.” The former term typically describes a vehicle that travels from place to place to perform services inside the vehicle. Examples of such vehicles include mobile homes or trailers. A “portable unit” exists when a supplier transports medical equipment to a particular location. Unlike with mobile facilities, the equipment on a portable unit is separate from and unattached to the vehicle.

- A PXRS can be either a mobile facility or portable unit, although it usually is the latter. A mobile IDTF, on the other hand, while it too can be either, is typically a mobile facility.
- Its base of operations. This is where personnel are dispatched from and where equipment is stored. It may or may not be the same address as the practice location.
- All geographic locations at which services will be rendered.
- Vehicle information if the services will be performed inside or from the vehicle. Copies of all licenses and registrations must be submitted as well, unless stated otherwise in this chapter or in another CMS directive.

3. Site Visits

If a PXRS submits an initial application, the contractor shall order a site visit through the Provider Enrollment, Chain and Ownership System (PECOS) after the contractor receives the tie-in notice (or approval letter) from the RO but before the contractor conveys Medicare billing privileges to the PXRS. This is to ensure that the supplier is still in compliance with CMS's enrollment requirements. The scope of the site visit will be consistent with *Section 10.6.20(A) and 10.6.20(B) of this chapter*. The National Site Visit Contractor (NSVC) will perform the site visit. The contractor shall not convey Medicare billing privileges to the supplier prior to the completion of the NSVC's site visit and the contractor's review of the results.

a. New/changed location

If a PXRS is (1) adding a new location or (2) changing the physical location of an existing location, the contractor shall order a site visit of the new/changed location through PECOS after the contractor receives notice of approval from the RO but before the contractor switches the supplier's enrollment record to "Approved." This is to ensure that the new/changed location is in compliance with CMS's enrollment requirements. The scope of the site visit will be consistent with *Section 10.6.20(A) and 10.6.20(B) of this chapter*. The NSVC will perform the site visit. The contractor shall not switch the supplier's enrollment record to "Approved" prior to the completion of the NSVC's site visit and the contractor's review of the results.

b. Revalidation

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

c. Reassignment

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

4. Additional Enrollment Information

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

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

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

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

5. PXRS and CHOWs

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

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

6. Additional Information

For more information on PXRSs, refer to:

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

F. Radiation Therapy Centers (RTCs)

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

1. General Background Information

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

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

2. Additional Information

For additional background on radiation therapy services, see:

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

G. Suppliers of Ambulance Services

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

1. General Background Information

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

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

2. Types of Ambulance Services

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

- a. Advanced Life Support, level 1 (ALS1) - Transportation by ground ambulance vehicle, medically necessary supplies and services, and either an ALS assessment by ALS personnel or the provision of at least one ALS intervention.
- b. Advanced Life Support, level 2 (ALS2) - Either transportation by ground ambulance vehicle, medically necessary supplies and services, and the administration of at least three medications by intravenous push/bolus or by continuous infusion, excluding crystalloid, hypotonic, isotonic, and hypertonic solutions (Dextrose, Normal Saline, Ringer's

Lactate); or transportation, medically necessary supplies and services, and the provision of at least one of the seven ALS procedures specified in § 414.605.

c. Air Ambulance (Fixed-Wing and Rotary-Wing) (See § 414.605 for specific definitions of fixed-wing and rotary-wing).

d. Basic Life Support (BLS) - Transportation by ground ambulance vehicle and medically necessary supplies and services, plus the provision of BLS ambulance services. The ambulance must be staffed by an individual who is qualified in accordance with state and local laws as an emergency medical technician-basic (EMT-Basic).

e. Paramedic ALS Intercept Services (PI) - Per § 414.605, EMT-Paramedic services furnished by an entity that does not furnish the ground transport, provided that the services meet the requirements in § 410.40(c). PI typically involves an arrangement between a BLS ambulance supplier and an ALS ambulance supplier, whereby the latter provides the ALS services and the BLS supplier provides the transportation component. Under § 410.40(c), PI must meet the following requirements:

- Be furnished in an area that is designated as a rural area (see § 410.40(c)(1) for more information on this requirement)
- Be furnished under contract with one or more volunteer ambulance services that meet the following conditions:
 - Are certified to furnish ambulance services as required under § 410.41;
 - Furnish services only at the BLS level; and
 - Be prohibited by state law from billing for any service
- Be furnished by a paramedic ALS intercept supplier that meets the following conditions:
 - Is certified to furnish ALS services as required in § 410.41(b)(2); and
 - Bills all the beneficiaries who receive ALS intercept services from the entity, regardless of whether or not those beneficiaries are Medicare beneficiaries.

f. Specialty Care Transport (SCT) - Inter-facility transportation of a critically injured or ill beneficiary by a ground ambulance vehicle, including medically necessary supplies and services, at a level of service beyond the scope of the EMT-Paramedic. SCT is necessary when a beneficiary's condition requires ongoing care that must be furnished by one or more health professionals in an appropriate specialty area (e.g., nursing, emergency medicine, respiratory care, cardiovascular care, or a paramedic with additional training.)

3. Ambulance Qualifications

a. Vehicle Design and Equipment

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

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

b. Vehicle Personnel

Per 42 CFR § 410.41(b)(1)(i) and (ii), a BLS vehicle must be staffed by at least two people, one of whom must be: (1) certified as an emergency medical technician by the state or local authority where the services are furnished, and (2) legally authorized to operate all lifesaving and life-sustaining equipment on board the vehicle.

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

4. Completion of the Form CMS-855B

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

5. Geographic Area: Single Contractor Jurisdiction

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

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

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

6. Geographic Area: Multiple States

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

- In more than one contractor's jurisdiction, it must submit a separate Form CMS-855B to each contractor.
- In more than one state but within the same contractor jurisdiction, the contractor shall review section 10.2.2(G)(6) of this chapter to determine whether a separate enrollment for the additional state is required.

7. Practice Location

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

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

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

Consider the following scenarios:

- a. The ambulance supplier is enrolling and performing services in multiple states but within only 1 contractor jurisdiction: The supplier would have to list on its Form CMS-855B each city/state/zip code in which it performs services. Its base of operations and all other practice locations would also have to be listed, and all licensure/certification requirements would have to be met for each state in which it performs services. However, separate Form CMS-855B applications for each state would only be required if all 5 conditions described in *Section 10.3.1(B)(1)(d)(iii) of this chapter* are met. (If separate applications are

not required, the contractor shall still create a separate Provider Enrollment, Chain and Ownership System (PECOS) record for each state.)

b. The ambulance supplier is enrolling (and has its base of operations) in Contractor Jurisdiction X. Its vehicles perform services in X and in adjacent Contractor Jurisdiction Y: The supplier would have to enroll with X and Y. For its Contractor X CMS-855B, the supplier would have to list all of the data mentioned in Example (a) above. For its Contractor Y CMS-855B, the supplier would have to (1) list the cities/zip codes in Y in which it performs services, (2) list its Jurisdiction X base of operations and any practice locations in Jurisdiction Y, and (3) meet all licensure/certification requirements for the state(s) in Y in which the supplier performs services.

8. Licensure Information

With respect to licensure:

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

9. Paramedic Intercept Information

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

10. Air Ambulances

Air ambulance suppliers must submit the following:

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

- If the air ambulance supplier or provider owns the aircraft, the owner's name on the FAA Part 135 certificate must be the same as the supplier's or provider's name on the enrollment application.
- If the air ambulance supplier or provider owns the aircraft but contracts with an air services vendor to supply pilots, training and/or vehicle

maintenance, the FAA Part 135 certificate must be issued in the name of the air services vendor. A certification from the supplier or provider must also attest that it has an agreement with the air services vendor and must list the date of that agreement. A copy of the FAA Part 135 Certificate must accompany the enrollment application.

- If the air ambulance supplier or provider leases the aircraft from another entity, a copy of the lease agreement must accompany the enrollment application. The name of the company leasing the aircraft from that other entity must be the same as the supplier's or provider's name on the enrollment application.

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

In addition:

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

11. Hospital-Based Ambulances

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

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

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

H. Intensive Cardiac Rehabilitation (ICR)

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

1. Background

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

2. ICR Enrollment

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

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

The contractor shall use specialty code 31 for these enrollments.

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

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

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

I. Independent Diagnostic Testing Facilities (IDTFs)

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

1. General Background Information

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

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

2. IDTF Standards

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

a. Operates its business in compliance with all applicable Federal and State licensure and regulatory requirements for the health and safety of patients.

- The purpose of this standard is to ensure that suppliers are licensed in the business and specialties being provided to Medicare beneficiaries. Licenses are required by State and/or Federal agencies to make certain that guidelines and regulations are being followed and to ensure that businesses are furnishing quality services to Medicare beneficiaries.
- The responsibility for determining what licenses are required to operate a supplier's business is the sole responsibility of the supplier. The contractor is not responsible for notifying any supplier of what licenses are required or that any changes have occurred in the licensure requirements. No exemptions to applicable State licensing requirements are permitted, except when granted by the State.
- The contractor shall not grant billing privileges to any business not appropriately licensed as required by the appropriate State or Federal agency. If a supplier is found providing services for which it is not properly licensed, billing privileges may be revoked and appropriate recoupment actions taken.

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

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

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

- IDTF suppliers that provide services remotely and do not see beneficiaries at their practice location are exempt from providing hand washing and adequate patient privacy accommodations.
- The requirements in 42 CFR §410.33(g)(3) take precedence over the guidelines in *Section 10.3.1(B)(1)(d) of this chapter* pertaining to the supplier's practice location requirements.

- The physical location must have an address, including the suite identifier, which is recognized by the United States Postal Service (USPS).

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

- (i) Maintain a catalog of portable diagnostic equipment, including diagnostic testing equipment serial numbers, at the physical site;
- (ii) Make portable diagnostic testing equipment available for inspection within 2 business days of a CMS inspection request; and
- (iii) Maintain a current inventory of the diagnostic testing equipment, including serial and registration numbers, and provide this information to the designated fee-for- service contractor upon request, and notify the contractor of any changes in equipment within 90 days.

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

- (i) Primary business phone located at the designated site of the business or within the home office of the mobile IDTF units.
- (ii) Telephone or toll free telephone numbers available in a local directory and through directory assistance.

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

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

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

- (i) Ensure that the insurance policy must remain in force at all times and provide coverage of at least \$300,000 per incident; and
- (ii) Notify the CMS designated contractor in writing of any policy changes or cancellations.

g. Agree not to directly solicit patients; this includes - but is not limited to - a prohibition on telephone, computer, or in-person contacts. The IDTF must accept only those patients referred for diagnostic testing by an attending physician who: (a) is furnishing a consultation or treating a

beneficiary for a specific medical problem, and (2) uses the results in the management of the beneficiary's specific medical problem. Non-physician practitioners may order tests as set forth in §410.32(a)(3).

- By the signature of the authorized official in section 15 of the Form CMS-855B, the IDTF agrees to comply with 42 CFR §410.33(g)(7).
- The supplier is prohibited from directly contacting any individual beneficiary for the purpose of soliciting business for the IDTF. This includes contacting the individual beneficiary by telephone or via door-to-door sales.
- There is no prohibition on television, radio or Internet advertisements, mass mailings, or similar efforts to attract potential clients to an IDTF.

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

- (i) The name, address, telephone number, and health insurance claim number of the beneficiary.
- (ii) The date the complaint was received; the name of the person receiving the complaint; and a summary of actions taken to resolve the complaint.
- (iii) If an investigation was not conducted, the name of the person making the decision and the reason for the decision.

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

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

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

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

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

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

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

- (ii) Maintain a visible sign posting its normal business hours.
- o. Enrolls in Medicare for any diagnostic testing services that it furnishes to a Medicare beneficiary, regardless of whether the service is furnished in a mobile or fixed-base location.
- p. Bills for all mobile diagnostic services that are furnished to a Medicare beneficiary, unless the mobile diagnostic service is part of a service provided under arrangement as described in section 1861(w)(1) of the Act. (Section 1861(w)(1) states that the term “arrangements” is limited to arrangements under which receipt of payments by the hospital, critical access hospital, skilled nursing facility, home health agency or hospice program (whether in its own right or as an agent), with respect to services for which an individual is entitled to have payment made under this title, discharges the liability of such individual or any other person to pay for the services.)

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

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

3. Leasing and Staffing

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

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

4. Sharing of Space and Equipment

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

diagnostic test with another Medicare-enrolled individual or organization. (See 42 CFR §410.33(g)(15).)

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

5. Multi-State IDTFs

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

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

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

6. IDTF Enrollment Information

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

7. One Enrollment per Practice Location

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

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

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

unit is in use at the IDTF's site in the site visit request so the site inspector will know to view the fixed mobile equipment as part of the IDTF.

8. Interpreting Physicians

a. Listing Interpreting Physicians

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

The contractor shall ensure and document that:

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

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

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

b. Changes of Interpreting Physicians

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

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

9. Effective Date of IDTF Billing Privileges

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

- (1) The filing date of the Medicare enrollment application that was subsequently approved by a MAC; or
- (2) The date the IDTF first started furnishing services at its new practice location.

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

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

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

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

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

11. IDTF Technicians Licensure and Certification Requirements

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

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

12. IDTF: Changes of Technicians

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

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

13. IDTF Supervising Physicians – General Principles

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

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

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

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

14. IDTF: Information about Supervising Physicians

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

In addition:

- Each physician of the group who actually performs an IDTF supervisory function must be listed.
- If a supervising physician has been recently added or changed, the updated information must be reported via a Form CMS-855B change request. The new physician must have met all of the supervising physician requirements at the time any tests were performed.
- If the contractor knows that a listed supervising physician has been listed with several other IDTFs, the contractor shall check with the

physician to determine whether he or she is still acting as supervising physician for these other IDTFs.

- If the supervising physician is enrolling in Medicare and does not intend to perform medical services outside of his/her role as a supervising physician:
 - The contractor shall still send the physician an approval letter (assuming successful enrollment) and issue a Provider Transaction Access Number
 - The physician shall list the IDTF's address as a practice location
 - The space-sharing prohibition in 42 CFR §410.33(g) does not apply in this particular scenario.

IDTF: General, Direct, and Personal Supervision

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

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

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

IDTF: Attestation Statement for Supervising Physicians

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

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

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

IDTF: Changes of Supervising Physicians

If a supervising physician is being added or changed, the updated information must be reported via a Form CMS-855B change request. The

new supervising physician must have met all of the necessary requirements at the time any tests were performed to perform services as a supervising physician.

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

15. Desk and Site Reviews

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

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

The contractor shall order the site visit through the Provider Enrollment, Chain and Ownership System. The National Site Visit Contractor (NSVC) will perform the site visit. The contractor shall not make a final decision regarding the application prior to the completion of the NSVC's site visit and the contractor's review of the results.

16. Mobile Units

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

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

- How they will perform these types of supervision on a mobile basis;
- What their responsibilities are; and

- That a patient's physician who is performing direct or personal supervision for the IDTF on their patient should be aware of the prohibition concerning physician self-referral for testing (in particular, this concerns potentially illegal compensation to the supervisory physician from the IDTF).

17. Addition of Codes

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

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

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

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

18. IDTF That Performs Diagnostic Mammography

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

19. IDTF Ownership of CLIA Laboratory

An IDTF may not perform or bill for CLIA tests. However, an entity with one tax identification number (TIN) may own both an IDTF and an independent CLIA laboratory. In such a situation, they should be separately

enrolled and advised to bill separately. The contractor shall also advise its claims unit to ensure that the CLIA codes are not being billed under the IDTF provider number.

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

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

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

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

A. Anesthesiology Assistants

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

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

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

B. Audiologists

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

1. Is licensed as an audiologist by the state in which the individual furnishes such services; or

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

C. Certified Nurse-Midwives

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

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

For more information on certified nurse midwives, refer to:

- Section 1861(gg) of the Social Security Act;
- Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, section 180; and
- Pub. 100-04, Medicare Claims Processing Manual, Chapter 12, section 130.1.

D. Certified Registered Nurse Anesthetists (CRNAs)

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

1. Is licensed as a registered professional nurse by the state in which the nurse practices;
2. Meets any licensure requirements the state imposes with respect to non-physician anesthetists;
3. Has graduated from a nurse anesthesia educational program that meets the standards of the Council on Accreditation of Nurse

Anesthesia Programs, or such other accreditation organization as may be designated by the Secretary; and

4. Meets the following criteria:

- a. Has passed a certification examination of the Council on Certification of Nurse Anesthetists, the Council on Recertification of Nurse Anesthetists, or any other certification organization that may be designated by the Secretary; or
- b. Is a graduate of a program described in paragraph (3) and within 24 months after that graduation meets the requirements of paragraph (4)(i).

For more information on CRNAs, refer to:

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

E. Clinical Nurse Specialists

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

1. Be a registered nurse who is currently licensed to practice in the state where he or she practices and be authorized to furnish the services of a clinical nurse specialist in accordance with state law.
2. Have a master's degree in a defined clinical area of nursing from an accredited educational institution or a Doctor of Nursing Practice (DNP) doctoral degree; and
3. Be certified as a clinical nurse specialist by a recognized national certifying body that has established standards for clinical nurse specialists and that is approved by the Secretary.

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

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

- f. AACN Certification Corporation; and
- g. National Board on Certification of Hospice and Palliative Nurses.

F. Clinical Psychologists

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

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

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

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

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

G. Clinical Social Workers

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

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

master's degree level social worker in an appropriate setting, such as a hospital, SNF, or clinic.

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

H. Nurse Practitioners

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

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

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

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

I. Occupational Therapists in Private Practice

1. Private Practice

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

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

AND

b. Bill Medicare only for services furnished in his or her private practice office space, or in the patient's home.

- i. A therapist's private practice office space refers to the location(s) where the practice is operated, in the state(s) where the therapist (and practice, if applicable) is legally authorized to furnish services, during the hours that the therapist engages in practice at that location. When services are furnished in private practice office space, such space must be owned, leased, or rented by the practice and used for the exclusive purpose of operating the practice.
- ii. A patient's home does not include any institution that is a hospital, a CAH, or a SNF.

AND

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

2. Regulatory Definition

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

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

administered by the National Board for Certification in Occupational Therapy, Inc. (NBCOT).

OR

On or before December 31, 2009--

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

OR

On or before January 1, 2008--

- (a) Graduated after successful completion of an occupational therapy program accredited jointly by the committee on Allied Health Education and Accreditation of the American Medical Association and the American Occupational Therapy Association; or
- (b) Is eligible for the National Registration Examination of the American Occupational Therapy Association or the National Board for Certification in Occupational Therapy.

OR

On or before December 31, 1977--

- (a) Had 2 years of appropriate experience as an occupational therapist; and
- (b) Had achieved a satisfactory grade on an occupational therapist proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service.

3. Occupational Therapist Educated Outside the United States

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

- a. Graduated after successful completion of an occupational therapist education program accredited as substantially equivalent to occupational

therapist entry-level education in the United States by one of the following:

- (i) The Accreditation Council for Occupational Therapy Education (ACOTE).
- (ii) Successor organizations of ACOTE.
- (iii) The World Federation of Occupational Therapists.
- (iv) A credentialing body approved by the American Occupational Therapy Association.

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

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

4. Occupational Therapists: Additional References

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

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

5. Other Enrollment Information

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

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

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

J. Physical Therapists in Private Practice

1. Physical Therapist in Private Practice

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

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

AND

- b. Bill Medicare only for services furnished in his or her private practice office space, or in the patient's home.

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

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

AND

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

2. Regulatory Definition

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

- (a) Graduated after successful completion of a physical therapist education program approved by one of the following:
 - (i) The Commission on Accreditation in Physical Therapy Education (CAPTE).
 - (ii) Successor organizations of CAPTE.

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

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

OR

On or before December 31, 2009--

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

(b) Meets both of the following:

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

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

OR

Before January 1, 2008--

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

(ii) The American Physical Therapy Association.

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

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

OR

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

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

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

OR

Before January 1, 1966--

- (i) Was admitted to membership by the American Physical Therapy Association; or
- (ii) Was admitted to registration by the American Registry of Physical Therapists; or

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

OR

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

3. Physical Therapist Trained Outside the United States

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

- a. Was graduated since 1928 from a physical therapy curriculum approved in the country in which the curriculum was located and in which there is a member organization of the World Confederation for Physical Therapy.
- b. Meets the requirements for membership in a member organization of the World Confederation for Physical Therapy.

4. Physical Therapists: Additional References

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

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

5. Site Visits of Physical Therapists in Private Practice

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

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

- i. Initial application – If a physical therapist (PT) or PT group submits an initial application for private practice, the contractor shall order a site visit through the Provider Enrollment, Chain and Ownership System (PECOS). This is to ensure that the supplier is in compliance with CMS’s enrollment requirements. The scope of the site visit will be consistent with *Section 10.6.20(A) and 10.6.20(B) of this chapter*.

The National Site Visit Contractor (NSVC) will perform the site visit. The contractor shall not convey Medicare billing privileges to the supplier prior to the completion of the NSVC's site visit and the contractor's review of the results.

ii. Revalidation – If a private practice PT or PT group submits a revalidation application, the contractor shall order a site visit through PECOS. This is to ensure that the supplier is still in compliance with CMS's enrollment requirements. The scope of the site visit will be consistent with *Section 10.6.20(A) and 10.6.20(B) of this chapter*.

The NSVC will perform the site visit. The contractor shall not make a final decision regarding the revalidation application prior to the completion of the NSVC's site visit and the contractor's review of the results.

iii. New/changed location – Unless CMS has directed otherwise, if a private practice PT or PT group is (1) adding a new location or (2) changing the physical location of an existing location, the contractor shall order a site visit of the new/changed location through PECOS. This is to ensure that the new/changed location is in compliance with CMS's enrollment requirements. The scope of the site visit will be consistent with *Section 10.6.20(A) and 10.6.20(B) of this chapter*.

The NSVC will perform the site visit. The contractor shall not make a final decision regarding the application prior to the completion of the NSVC's site visit and the contractor's review of the results.

6. Physical Therapists: Additional Site Visit Information

NOTE: The contractor shall also view the following:

- In section 2A of the Form CMS-855B application, physical and occupational therapy groups are denoted as “Physical/Occupational Therapy Group(s) in Private Practice.” If a supplier that checks this box in section 2A is exclusively an occupational therapy group in private practice – that is, there are no physical therapists in the group – the contractor shall process the application using the procedures in the “limited” screening category. No site visit is necessary. If there is at least one physical therapist in the group, the application shall be processed using the procedures in the “moderate” screening category. A site visit by the NSVC is required, unless CMS has directed otherwise.
- If an entity is enrolled as a physician practice and employs a physical therapist within the practice, the practice itself falls within the “limited” screening category. This is because the entity is enrolled as a physician practice, not a physical therapy group in private practice. However, this does not exempt the physical therapist from screening required at the “moderate” risk level.
- If a newly-enrolling private practice physical therapist lists several practice locations, the enrollment contractor has the discretion to determine the location at which the NSVC will perform the required site visit.
- Unless CMS has directed otherwise, a site visit by the NSVC is required when a physical therapist submits an application for private practice

initial enrollment and reassignment of benefits (Form CMS-855I and Form CMS-855R). However, a site visit is not required for an enrolled private practice physical therapist who is reassigning his or her benefits only (Form CMS-855R).

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

7. Other Enrollment Information

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

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

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

K. Physicians

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

1. Doctors of:

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

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

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

L. Physician Assistants (PAs)

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

- Have graduated from a physician assistant educational program that is accredited by the Accreditation Review Commission on Education for the Physician Assistant (its predecessor agencies, the Commission on Accreditation of Allied Health Education Programs (CAAHEP) and the Committee on Allied Health Education and Accreditation (CAHEA)); or
- Have passed the national certification examination that is administered by the National Commission on Certification of Physician Assistants (NCCPA); and
- Be licensed by the state to practice as a physician assistant.

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

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

1. Other Enrollment Information

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

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

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

M. Psychologists Practicing Independently

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

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

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

Other Enrollment Information

The contractor shall ensure that all persons who check "Psychologist Billing Independently" in section 2D2 of the CMS-855I answer all questions in section

2J. If the supplier answers “no” to question 1, 2, 3, 4a, or 4b, the contractor shall deny the application.

N. Registered Dietitians

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

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

There are two exceptions to these requirements:

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

O. Speech Language Pathologists in Private Practice

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

1. Be legally authorized (if applicable, licensed, certified, or registered) to engage in the private practice of speech-language pathology by the state in which he or she practices, and practice only within the scope of his or her license and/or certification.
2. Engage in the private practice of speech-language pathology as an individual, in one of the following practice types:
 - a. An unincorporated solo practice
 - b. An unincorporated partnership or unincorporated group practice
 - c. An unincorporated solo practice, partnership, or group practice, or a professional corporation or other incorporated speech-language pathology practice

- d. An employee of a physician group
- e. An employee of a group that is not a professional corporation

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

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

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

10.2.4 - Other Medicare Part B Services

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

A. Residents and Interns

1. General Background Information

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

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

2. Interns are Ineligible to Enroll in the Medicare Program

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

B. Diabetes Self-Management Training (DSMT)

DSMT Background

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

requires the submission of an application fee, the fee shall be submitted with the application.

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

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

For more information on DSMT, refer to:

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

C. Mass Immunizers Who Roster Bill

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

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

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

In addition:

- The effective date provision in 42 CFR § 424.520(d) does not apply to the enrollment of mass immunizers. This is because the individual/entity is not enrolling as a physician, non-physician practitioner, physician group or non-physician practitioner group.
- In section 4 of the Form CMS-855, the supplier need not list each off-site location (e.g., county fair, shopping mall) at which it furnishes services. It need only list its base of operations (e.g., county health department headquarters, drug store location).

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

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

D. Advanced Diagnostic Imaging

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

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

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

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

10.2.5 – Suppliers That Enroll Via the Form CMS-855S

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

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

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

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

2. DMEPOS Supplier Accreditation

a. General Requirement

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

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

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

b. Exemptions

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

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

c. Special Situations

Changes of Ownership

i. Change of Ownership and Accreditation

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

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

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

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

iii. Accreditation and Deactivation/Revocation

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

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

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

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

- Low Risk (e.g., national drug store chains)
- Limited Risk (e.g., prosthetist in a low fraud area)
- Medium Risk (e.g., midsize general medical supplier in a high fraud area)

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

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

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

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

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

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

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

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

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

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

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

f. Fraud Level Indicator Standards

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

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

g. Alert Codes for DME Suppliers

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

| Alert Code | Definition |
|----------------|--|
| A | Possible fraudulent or abusive claims identified |
| B | Overpayments |
| D requirements | Violations of disclosure of ownership |
| E | Violations of participation agreements |
| L | Suspended by contractor outside alert code process |
| M | Supplier is going through claims appeal process |

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

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

| | |
|---|--|
| C | Violations of supplier standards |
| F | Excluded by the Office of Inspector General or debarred per the GSA debarment list |
| H | Meets supplier standards; however, the NSC recommends increased scrutiny by the contractor (initiated by NSC-MAC only) |
| N | Supplier being investigated under the "Do Not Forward" initiative (initiated by NSC only) |
| Q | Low Risk Fraud Level Indicator |
| R | Limited Risk Fraud Level Indicator |
| S | Medium Risk Fraud Level Indicator |
| T | High Risk Fraud Level Indicator |

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

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

3. Surety Bonds

a. Background

i. Surety Bond Exemptions

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

- (1) Government-operated DMEPOS suppliers are exempted if the supplier has provided CMS with a comparable surety bond under State law.
- (2) State-licensed orthotic and prosthetic personnel (which, for purposes of the surety bond requirement, does not include pedorthists) in private practice making custom- made orthotics and prosthetics are exempted if—
 - The business is solely-owned and operated by the orthotic and prosthetic personnel, and

- The business is only billing for orthotic, prosthetics, and supplies.

(3) Physicians and non-physician practitioners, as defined in section 1842(b)(18) of the Social Security Act, are exempted if the items are furnished only to the physician or non-physician practitioner's own patients as part of his or her physician service. The non-physicians covered under this exception are: physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse-midwives, clinical social workers, clinical psychologists, and registered dietitians or nutrition professionals.

(4) Physical and occupational therapists in private practice are exempted if—

- The business is solely-owned and operated by the physical or occupational therapist;
- The items are furnished only to the physical or occupational therapist's own patients as part of his or her professional service; and
- The business is only billing for orthotics, prosthetics, and supplies.

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

b. Bond Submission

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

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

c. Amount and Basis

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

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

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

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

d. Bond Terms

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

- A guarantee that the surety will - within 30 days of receiving written notice from CMS containing sufficient evidence to establish the surety's liability under the bond of unpaid claims, civil monetary penalties (CMPs), or assessments - pay CMS a total of up to the full penal amount of the bond in the following amounts:
- The amount of any unpaid claim, plus accrued interest, for which the DMEPOS supplier is responsible, and
- The amount of any unpaid claims, CMPs, or assessments imposed by CMS or the OIG on the DMEPOS supplier, plus accrued interest.

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

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

e. Sureties

The list of sureties from which a bond can be secured is found at Department of the Treasury's "Listing of Certified (Surety Bond) Companies;" the Web site is

https://www.fiscal.treasury.gov/fsreports/ref/suretyBnd/c570_a-z.htm.

For purposes of the surety bond requirement, these sureties are considered "authorized" sureties, and are therefore the only sureties from which the supplier may obtain a bond.

f. Bond Cancellations and Gaps in Coverage

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

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

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

g. Reenrollment and Reactivation

The supplier must furnish the paperwork described in subsection (A)(4) above with any CMS-855S reenrollment or reactivation application it

submits to the NSC unless it already has the information on file with the NSC. For example, if a supplier has submitted a continuous surety bond to the NSC prior to submission of its reenrollment application, a new copy of surety bond is not be required unless the NSC specifically requests it.

h. Surety Bond Changes

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

i. Claims against Surety Bonds

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

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

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

j. Unpaid Claims

i. Background

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

The policies in this section 10.2.5(A) only apply to overpayment determinations relating to demands first made on or after March 3, 2009. A surety is liable for any overpayments based on dates of service occurring during the term of the surety bond. (For purposes of determining surety liability, the date of the initial demand letter was sent to the provider is the date on which the service was performed/furnished.) Even if the overpayment determination is made after the expiration of the surety bond, the surety remains liable if the *date of service* was within the surety bond coverage period. In short, *the date of service – rather than the date of the overpayment determination*, the date the overpayment or demand letter was sent to the supplier---is the principal factor in ascertaining surety liability.

As an illustration, assume that a supplier has a surety bond with Company X on August 1, 2015. It performs a service on October 1, 2015. The supplier ends its coverage with Company X effective January 1, 2016 and obtains a new surety bond with Company Y effective that same date. On February 1,

2016, CMS determines that the October 1, 2015 service resulted in an overpayment; on March 2, 2016, CMS sends an overpayment demand letter to the supplier. While the overpayment determination and the sending of the demand letter occurred during Company Y's coverage period, the date of service was within the Company X coverage period. Thus, liability (and responsibility for payment) rests with Company X, even *though the supplier no longer has a surety bond with X.*

k. Collection

i. Delinquency Period

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

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

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

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

ii. Request for Payment from Surety

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

(NOTE: Under federal law, a delinquent debt must be referred to the Department of Treasury within 120 days. (Per the chart below, this represents Day 150 of the entire collection cycle.) To ensure that the DME MAC meets this 120-day limit yet has sufficient time to prepare

the surety letter as described in the following paragraph, it is recommended that the DME MAC send the ITR letter several days prior to the 90-day limit referenced in the previous paragraph. This will give the DME MAC a few additional days beyond the 30-day deadline referenced in the next paragraph to send the surety letter.)

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

1. If a DMEPOS supplier has withdrawn from Medicare or has had its enrollment deactivated or revoked, the contractor shall send the ITR and the surety letter on the earliest possible day.
2. If the supplier has an extended repayment schedule (ERS) and is currently making payments, the DME MAC shall not send an ITR letter or a surety letter. If the DME MAC is currently reviewing an ERS application from the supplier, the contractor shall delay sending the ITR letter and the surety letter until after the ERS review is complete.
3. If the aggregated principal balance of the debt is less than \$25, the DME MAC shall not send an ITR letter or a surety letter. It shall instead follow the instructions in CMS Pub. 100-06, chapter 4 regarding collection of the overpayment.
4. If the DME MAC believes the debt will be collected through recoupment, it shall not send an ITR letter or a surety letter. It shall instead follow the instructions in Pub. 100-06, chapter 4 regarding collection of the overpayment.
5. If the supplier has had a recent offset, the DME MAC may wait to see if future offsets will close the debt, without sending the surety letter. If the debt is still not paid in full or an ERS has not been established, the DME MAC shall send the surety letter no later than the 115th day after the initial demand letter was sent.

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

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

The surety letter shall:

- Follow the format of the applicable model letter *found in Section 10.7.16 of this chapter.*

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

m. Overpayment Services Report

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

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

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

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

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

The DME MAC shall only seek repayment up to the full penal sum amount of the surety bond. Thus, if the supplier has a \$60,000 unpaid claim and the amount of the supplier’s bond coverage is \$50,000, the DME MAC shall only seek the \$50,000 amount. The remaining \$10,000 will have to be obtained from the supplier via the existing overpayment collection process.

i. Follow-Up Contact

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

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

Payment must be received by May 1, or 30 days from the original date of the letter.

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

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

o. Verification of Payment

i. Full Payment of the Claim is Made

If full payment (including interest, as applicable) is made within the aforementioned 30-day period, the DME MAC shall, no later than 10 calendar days after payment was made:

A. Update all applicable records to reflect that payment was made. (Payment from the surety shall be treated as payment from the supplier for purposes of said record updates.)

B. Send a mailed, faxed, or (preferably) e-mailed letter to the supplier (on which the NSC shall be copied):

- Stating that payment has been made, the date the payment was received, and the amount of the payment
- Containing the following quoted verbiage:

“You must, within 30 calendar days of the date of this letter, obtain and submit to the NSC additional surety bond coverage in the amount of (insert the amount that the surety paid) so as to ensure that your total coverage equals or exceeds the required \$50,000 amount” (or higher if an elevated bond amount is involved due to a final adverse action). **Failure to timely do so will result in the revocation of your Medicare enrollment.**

“Additional surety bond coverage may be obtained by (1) adding to the amount of your existing surety bond so as to equal or exceed \$50,000, or (2) cancelling your current surety bond and securing a new \$50,000 surety bond. (Obtaining a separate (insert the amount the surety paid) surety bond is impermissible.) In either case, the effective date of the additional coverage must be on or before the date that you submit the additional coverage to the NSC.

If the NSC does not receive the additional bond coverage within this 30-day period, it shall revoke the DMEPOS supplier’s Medicare enrollment under § 424.535(a)(1) in accordance with

existing procedures. (The effective date of revocation shall be the date on which the DME MAC received payment from the surety.) **It is important that the NSC (1) monitor the supplier's surety bond status upon receiving a copy of the DME MAC's letter to the supplier and (2) take prompt action against the supplier (consistent with existing procedures) if the supplier does not secure and timely submit the required additional coverage.**

ii. No Payment of the Claim Made

If the surety fails to make any payment within 30 calendar days of the date of the letter to the surety, the DME MAC shall:

- A. Refer the debt to the Department of Treasury (by HIGLAS on the 120-day deadline) immediately upon the expiration of said 30-day timeframe (i.e., preferably on the same day or the day after, but in all cases no later than the 120-day deadline for sending delinquent debts to the Department of Treasury) and as outlined in Pub. 100-06, chapter 4;
- B. No later than 14 days after the 30-day period expires, contact the surety via e-mail or telephone to ascertain the reason for non-payment. Only one contact is necessary. A voice mail message may be left. The contractor shall document any attempts to contact the surety by telephone and the content of any resultant conversations with the surety.
- C. No later than 14 days after Step 2 has been completed – and if full payment still has not been received -- send the letter *found in Section 10.7.16 of this chapter.*
- D. Include information relating to the surety's non-payment in the report identified in section 10.2.5(A)(3)(o)(ii).

iii. Partial Payment of the Claim is Made

If the surety pays part of the claim within the 30-day period and a balance is still due and owing, the DME MAC shall do the following:

- A. Refer the unpaid debt to the Department of Treasury (by HIGLAS on the 120-day deadline) immediately upon the expiration of said 30-day timeframe (i.e., preferably on the same day or the day after, but in all cases no later than the 120-day deadline for sending delinquent debts to the Department of Treasury) and as outlined in Pub. 100-06, chapter 4;
- B. No later than 14 days after the 30-day period expires, contact the surety via e-mail or telephone to ascertain the reason for the partial non-payment. Only one contact is necessary. A voice mail message may be left. The contractor shall document any attempts to contact the surety by telephone and the content of any resultant conversations with the surety.

C. No later than 14 days after Step (ii) has been completed – and if full payment still has not been received -- send the letter *found in Section 10.7.16 of this chapter*.

D. Include information relating to the surety's partial non-payment in the report identified in section 10.2.5(A)(3)(o)(iii).

E. No later than 10 calendar days after the partial payment was made:

- Update all applicable records to reflect that partial payment was made. (Payment from the surety shall be treated as payment from the supplier for purposes of said record updates.)
- Send a mailed, faxed, or (preferably) e-mailed letter to the supplier (on which the NSC shall be copied):
- Stating that partial payment was made, the date the payment was received, and the amount of said payment
- Containing the following quoted verbiage:

“You must, within 30 calendar days of the date of this letter, obtain and submit to the NSC additional surety bond coverage in the amount of (insert the amount that the surety paid) so as to ensure that your total coverage equals or exceeds the required \$50,000 amount” (or higher if an elevated bond amount is involved due to a final adverse action). **Failure to timely do so will result in the revocation of your Medicare enrollment.**

“Additional surety bond coverage may be obtained by (1) adding to the amount of your existing surety bond so as to equal or exceed \$50,000, or (2) cancelling your current surety bond and securing a new \$50,000 surety bond. (Obtaining a separate (insert the amount the surety paid) surety bond is impermissible.) In either case, the effective date of the additional coverage must be on or before the date that you submit the additional coverage to the NSC.”

If the NSC does not receive the additional bond coverage within this 30-day period, it shall revoke the DMEPOS supplier's Medicare enrollment under § 424.535(a)(1) in accordance with existing procedures. (The effective date of revocation shall be the date on which the DME MAC received payment from the surety.) It is important that the NSC (1) monitor the supplier's surety bond status upon receiving a copy of the DME MAC's letter to the supplier and (2) take prompt action against the supplier (consistent with existing procedures) if the supplier does not secure and timely submit the required additional coverage.

iv. Successful Appeal

If the supplier successfully appeals the overpayment and the surety has already made payment to the DME MAC on the overpayment, the

DME MAC shall – within 30 calendar days of receiving notice of the successful appeal - notify the surety via letter of the successful appeal and repay the surety via check or money order.

v. Summary

The following chart outlines the timeframes involved in the surety bond collection process for overpayments:

| | |
|---------|------------------------------------|
| Day 1 | Initial Demand Letter Sent |
| Day 31 | Debt is Delinquent/Interest Starts |
| Day 41 | Recoupment Starts |
| Day 66 | Intent to Refer Letter Sent |
| Day 115 | Surety Bond Letter Sent |
| Day 150 | Referral to Treasury |

4. Surety Bonds: Claims Pertaining to Assessments and Civil Monetary Penalties (CMPs)

a. Request for Payment from Surety

Per 42 CFR §424.57(a), an assessment is defined as a “sum certain that CMS or the OIG may assess against a DMEPOS supplier under Titles XI, XVIII, or XXI of the Social Security Act.” Under 42 CFR §424.57(a), a CMP is defined as a sum that CMS has the authority, as implemented by 42 CFR §402.1(c) (or the OIG has the authority, under section 1128A of the Act or 42 CFR Part 1003) to impose on a supplier as a penalty.

CMS will notify the DME MAC of the need for the latter to collect payment from the surety on an assessment or CMP imposed against a particular bonded DMEPOS supplier. Upon receipt of this notification, the DME MAC shall – regardless of the amount of the assessment or CMP - notify the surety via letter that, in accordance with 42 CFR § 424.57(d)(5)(i)(B), payment of the assessment or CMP must be made within 30 calendar days from the date of the letter. The letter (on which the NSC and the supplier/debtor shall be copied) shall:

- Follow the format of the applicable model letter *found in Section 10.7.16 of this chapter.*
- Identify the specific amount to be paid and be accompanied by “sufficient evidence.” This includes all documentation that CMS (in its notification to the DME MAC as described above) requests the DME MAC to include with the letter (e.g., OIG letter).
- State that payment shall be made via check or money order and that the Payee shall be CMS.
- Identify the address to which payment shall be sent.

i. Follow-Up Contact

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

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

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

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

ii. Verification of Payment

A. Full Payment of the Claim is Made

If full payment (including interest, as applicable) is made within 30 calendar days of the date of the letter to the surety, the DME MAC shall, no later than 10 calendar days after payment was made:

1. Update all applicable records to reflect that payment was made. (Payment from the surety shall be treated as payment from the supplier for purposes of said record updates.)
2. Notify the applicable CMS Regional Office (RO) via letter or e-mail that payment was made.
3. If the OIG imposed the CMP or assessment, notify the OIG via letter that payment was made.
4. Send a mailed, faxed, or (preferably) e-mailed letter to the supplier (on which the NSC shall be copied):
 - Stating that payment has been made, the date the payment was received, and the amount of said payment
 - Containing the following quoted verbiage:

“You must, within 30 calendar days of the date of this letter, obtain and submit to the NSC additional surety bond coverage in the amount of (insert the amount that the surety paid) so as to ensure that your total coverage equals or exceeds the required \$50,000 amount” (or higher if an elevated bond amount is involved due to a final adverse action). **Failure to timely do so will result in the revocation of your Medicare enrollment.**

“Additional surety bond coverage may be obtained by (1) adding to the amount of your existing surety bond so as to equal or exceed \$50,000, or (2) cancelling your current surety bond and securing a new \$50,000 surety bond. (Obtaining a separate (insert the amount the surety paid) surety bond is impermissible.) In either case, the effective date of the additional coverage must be on or before the date that you submit the additional coverage to the NSC.”

If the NSC does not receive the additional bond coverage within this 30-day period, it shall revoke the DMEPOS supplier’s Medicare enrollment under § 424.535(a)(1) enrollment in accordance with existing procedures. (The effective date of revocation shall be the date on which the DME MAC received payment from the surety.) It is important that the NSC (1) monitor the supplier’s surety bond status upon receiving a copy of the DME MAC’s letter to the supplier and (2) take prompt action against the supplier (consistent with existing procedures) if the supplier does not secure and timely submit the required additional coverage.

B. No Payment of the Claim is Made

If the surety fails to make any payment within the aforementioned 30-day timeframe, the DME MAC shall:

1. Continue collection efforts as outlined in Pub. 100-06, chapter 4;
2. No later than 14 days after the 30-day period expires, contact the surety via e-mail or telephone to ascertain the reason for non-payment. Only one contact is necessary. A voice mail message may be left. The contractor shall document any attempts to contact the surety by telephone and the content of any resultant conversations with the surety.
3. No later than 14 days after Step 2 has been completed – and if full payment still has not been received -- send the letter *found in Section 10.7.16 of this chapter.*
4. Include information relating to the surety’s non-payment in the report outlined in section 10.2.5(A)(3)(o)(ii).

C. Partial Payment of the Claim is Made

If the surety pays part of the claim within the 30-day period and a balance is still due and owing, the DME MAC shall do the following:

1. Continue collection efforts as outlined in Pub. 100-06, chapter 4;
2. No later than 14 days after the 30-day period expires, contact the surety via e-mail or telephone to ascertain the reason for the partial non-payment. Only one contact is necessary. A voice mail message may be left. The contractor shall document any attempts to contact the surety by telephone and the content of any resultant conversations with the surety.
3. No later than 14 days after Step (ii) has been completed – and if full payment still has not been received -- send the letter *found in Section 10.7.16 of this chapter*.
4. Include information relating to the surety's partial non-payment in the report identified in 10.2.5(A)(3)(o)(iii).
5. No later than 10 calendar days after the partial payment was made:
 - Update all applicable records to reflect that partial payment was made. (Payment from the surety shall be treated as payment from the supplier for purposes of said record updates.)
 - Send a mailed, faxed, or (preferably) e-mailed letter to the supplier (on which the NSC shall be copied):
 - Stating that partial payment was made, the date the payment was received, and the amount of said payment
 - Containing the following quoted verbiage:

“You must, within 30 calendar days of the date of this letter, obtain and submit to the NSC additional surety bond coverage in the amount of (insert the amount that the surety paid) so as to ensure that your total coverage equals or exceeds the required \$50,000 amount” (or higher if an elevated bond amount is involved due to a final adverse action). **Failure to timely do so will result in the revocation of your Medicare enrollment.**

“Additional surety bond coverage may be obtained by (1) adding to the amount of your existing surety bond so as to equal or exceed \$50,000, or (2) cancelling your current surety bond and securing a new \$50,000 surety bond. (Obtaining a separate (insert the amount the surety paid) surety bond is impermissible.) In either case, the effective date of the additional coverage must be on or before the date that you submit the additional coverage to the NSC.”

If the NSC does not receive the additional bond coverage within this 30-day period, it shall revoke the DMEPOS supplier's Medicare enrollment under §424.535(a)(1) in accordance with existing procedures. (The effective date of revocation shall be the date on which the DME MAC received payment from the surety.) It is important that the NSC (1) monitor the supplier's surety bond status upon receiving a copy of the DME MAC's letter to the supplier and (2) take prompt action against the supplier (consistent with existing procedures) if the supplier does not secure and timely submit the required additional coverage.

D. Successful Appeal

If the DMEPOS supplier successfully appeals the CMP or assessment and the surety has already made payment, CMS will – within 30 days of receiving notice of the successful appeal - notify the surety via letter of the successful appeal and repay the surety.

5. Reporting Requirements

- DME MACs shall compile a report on a quarterly basis in the format prescribed in existing CMS directives. The report will capture the following elements:
 - Number of account receivables (debts) reviewed for possible surety bond letter development
 - Number of debts sent to the surety for recovery
 - Amounts recovered directly from sureties (1) during the quarter in question, and (2) since March 3, 2009 (that is, the total/cumulative amount collected since the beginning of the surety bond collection process)
 - Amounts paid by suppliers after the debt was referred to the surety for collection. The report shall include the (1) amount for the quarter in question and (2) total/cumulative amount since March 3, 2009.
 - Names of suppliers and NSC numbers for which letters were sent to the surety and/or surety bond recoveries were received
 - Names of suppliers on whose surety bond(s) the surety made payment in the last quarter and to whom the DME MAC consequently sent notice to the supplier that it must obtain additional surety bond coverage to reach the \$50,000 threshold.
 - Names and addresses of sureties that have failed to make payment within the quarterly period. For each instance of non-payment, the report shall identify (a) the amount that was requested, (b) the amount that was paid (if any), (3) the name and tax identification number of the supplier in question, and (4) the reason the surety did not pay (to the extent this can be determined).

The quarterly reports shall encompass the following time periods: January through March, April through June, July through August, and September through December. Reports shall be submitted to the Provider Enrollment & Oversight Group (with a copy to the MAC COR) --- via the following e-mail address: XXXXXXXX@cms.hhs.gov --- by the 10th day of the month following the end of the reporting quarter. Information on surety collections shall be reported once for each demand letter. That action shall be reported only when the collection process has been fully completed for that specific identified overpayment, which may be comprised of multiple claims. For example, suppose the surety was sent a letter in December but its payment was not received until January. That action would be documented in the report encompassing the months of January, February, and March.

B. Indian Health Services (IHS) Facilities' Enrollment as DMEPOS Suppliers

1. Background

The National Supplier Clearinghouse (NSC) shall enroll IHS facilities as DMEPOS suppliers in accordance with (a) the general enrollment procedures cited in chapter 10, (b) the statement of work contained in the NSC contract with Medicare, and (c) the special procedures cited in this section.

For enrollment purposes, Medicare recognizes two types of IHS facilities: (1) facilities wholly owned and operated by the IHS, and (2) facilities owned by the IHS but tribally operated or totally owned and operated by a tribe. CMS will provide the NSC with a list of IHS facilities that distinguishes between these two types.

On the list, the NSC shall use the column entitled, "FAC OPERATED BY", for this purpose.

2. Enrollment

The provider/supplier shall complete the Form CMS-855S in accordance with the instructions shown therein.

Facilities that are:

- Totally owned and operated by the IHS are considered governmental organizations. An Area Director of the IHS must sign section 15 of the Form CMS-855S, be listed in section 9 of the form, and sign the letter required under section 8 of the form that attests that the IHS will be legally and financially responsible in the event there is any outstanding debt owed to CMS.
- Tribally operated are considered tribal organizations. Section 15 of the Form CMS-855S must be signed by a tribal official who meets the definition of an "authorized official" under 42 CFR § 424.502. The individual must also be listed in section 9 of the form, and must sign the letter required under section 8 of the form that attests that the tribe will be legally and financially responsible in the event there is any outstanding debt owed to CMS.

3. Supplier Standards, Exceptions and Site Visits

All IHS facilities, whether operated by the IHS or a tribe:

- Shall meet all required standards, with the exception of:
- The comprehensive liability insurance requirements under 42 CFR 424.57(c)(10).
- The requirement to provide State licenses for their facility/business. For example, if the DMEPOS supplier indicates on its application that it will be providing hospital beds and is located in a State that requires a bedding license, such licensure is not required. However, if it provides a DMEPOS item that requires a licensed professional in order to properly provide the item, it shall provide a copy of the professional license. The licensed professional can be licensed in any State or have a Federal license (e.g., a pharmacy does not need a pharmacy license, but shall have a licensed pharmacist).
- Shall, like all other DMEPOS suppliers, undergo site visits in accordance with *Section 10.6.20(A) and 10.6.20(B) of this chapter*. (This includes all hospitals and pharmacies enrolling as DMEPOS suppliers.)

4. Provider Education for IHS Facilities

The NSC shall ensure that its Web site includes the information contained in this section 10.2.5(B) that is specific to enrollment of IHS facilities (whether operated by the IHS or a tribe).

5. Specialty Codes

The NSC shall apply the specialty code A9 (IHS) to all IHS enrollments (whether operated by the IHS or a tribe). However, the specialty code A9/A0 shall be applied to facilities that are IHS/tribal hospitals.

Other specialty codes should be applied as applicable (e.g., pharmacies).

C. Pharmacies' Enrollment as DMEPOS Suppliers

Refer to 10.2.2(D) for a discussion of pharmacy enrollment via the Form CMS-855B (i.e., pharmacy not enrolling as a DMEPOS supplier).

1. Compliance Standards for Pharmacy Accreditation

The National Supplier Clearinghouse (NSC) shall not require that a pharmacy be accredited as a condition of enrollment before January 1, 2011.

The NSC-Medicare Administrative Contractor (MAC) shall determine which enrolled suppliers are pharmacies that are not accredited and who will be enrolled for 5 calendar years prior to January 1 of the next calendar year. The NSC-MAC shall then send a notice of revocation by January 10, 2011, to all enrolled pharmacies that are not accredited and who will not be enrolled for 5 calendar years as of January 1, 2011.

The NSC-MAC shall prepare a letter which enables all individually enrolled practice locations of pharmacies who have been enrolled for 5 calendar years prior to January 1, 2011, to attest that they are exempt from the requirement to be accredited because their total durable medical equipment, prosthetics orthotics and supplies (DMEPOS) billings subject to accreditation are less than 5 percent of their total pharmacy sales, as determined based upon the total pharmacy sales of the pharmacy for the previous 3 calendar or fiscal years. The letter shall cite that the attestation requires the signature of the authorized or delegated official of the entity. The authorized and delegated officials are defined in Section 15, of the Medicare Enrollment Application (CMS-855S), and as described in the internet enrollment application version of the Provider Enrollment, Chain and Ownership System (PECOS). Before mailing the letters, the NSC-MAC shall obtain NSC project officer approval of the letter. The mailing shall be in the form of an endorsement letter with an enclosed stamped self-addressed envelope. The mailing should be performed between October 1, 2010 and October 31, 2010. For pharmacies with more than one practice location, the letters shall cite the need for each individually enrolled practice location to attest that they are exempt from the accreditation requirements. New locations of enrolled chain pharmacies shall not be considered to have been enrolled for 5 calendar years. Pharmacies that have had a change of ownership in the prior 5 years which resulted in a change in their legal business entity, including a change in their tax identification number (TIN), shall not qualify for an attestation accreditation exemption and therefore shall not be sent the attestation letter.

The NSC-MAC shall review the attestations received from pharmacies. Pharmacies that properly signed the attestation letter shall be given an accreditation status of exempt. The NSC shall make attempts to assist and follow-up with pharmacy suppliers that have not submitted or properly completed their attestations. The NSC-MAC shall send a notice of revocation by January 10, 2011, to all enrolled pharmacies who were sent an attestation letter and have not properly completed it as of the date of the notice of revocation. The notice of revocation shall cite that the revocation is for a lack of required accreditation.

Between April 1, 2011 and April 30, 2011, the NSC-MAC shall compile a sample listing of at least 10 percent of the pharmacies that have submitted an NSC accepted attestation exempting them from accreditation. The NSC-MAC shall develop a letter to be sent to pharmacies that will be audited to determine if their accreditation exemption attestations are correct. The letter shall request submission of evidence substantiating that the validity of the pharmacy supplier's attestation. At a minimum, requested materials for this evidence shall include a certification by an accountant on behalf of the pharmacy or the submission of tax returns filed by the pharmacy during the relevant periods. The NSC-MAC shall obtain NSC project officer approval of the letter. Within 45 days after project officer approval of the letter the NSC-MAC shall mail a copy of the letter to the random sample of pharmacies which claimed exemption through an attestation. The NSC-MAC shall determine the acceptability of the replies received in response to the audit verification random sample mailing. The NSC shall use DMEPOS billing data for only products and services requiring accreditation to assist in the determination. The NSC shall make attempts to assist and follow-up with pharmacy suppliers that have not submitted or properly completed their audit verifications. The NSC-MAC shall consult with the NSC project

officer in cases where they are uncertain as to the acceptability of the supplier's response to the audit request. By June 30, 2011, the NSC-MAC shall send a notice of revocation to all enrolled pharmacies that were sent an audit verification letter who did not submit satisfactory evidence that they were in compliance with the requirements to obtain an accreditation exemption. The notice of revocation shall cite that the revocation is for a lack of required accreditation.

The NSC-MAC shall follow the procedures shown above concerning issuance of attestation letters and audit survey letters for all succeeding years after they have been performed for the first time.

10.4 – Medicare Enrollment: Contractor Processing Duties

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

A. Processing Duties – Introduction

1. Overview of Processing Duties

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

- a. Contractor receives application
- b. Contractor reviews application and verifies data thereon
- c. If (a) required data/documentation is missing, (b) data cannot be verified, and/or (c) there are data discrepancies, contractor requests missing/clarifying information from the provider.
- e. If applicable, contractor (a) verifies any newly furnished data, or (b) seeks additional data/clarification from provider.
- f. Certified providers and suppliers must first coordinate with Survey and Certification and the State Agency prior to rendering a final determination.
- g. Final determination

Sections 10.4(A)(2) through 10.4(F) are structured so as to generally follow Steps 10.4(A)(1)(a) through 10.4(A)(1)(f) above.

2. Processing Duties Regarding Non-CMS-855 and CMS- 20134 Enrollment Forms

There are situations where the contractor processes non-CMS-855 and CMS- 20134 forms and other documentation relating to provider enrollment. Such activities include:

- EFT agreements (Form CMS-588) submitted alone
- "Do Not Forward" issues
- Par agreements (Form CMS-460)
- Returned remittance notices

- Informational letters received from other contractors
- Diabetes self-management notices
- Verification of new billing services
- Paramedic intercept contracts
- 1099 issues that need to be resolved
- Opt-Out Affidavits

Unless specified otherwise in this chapter or another CMS directive, the contractor should not create a logging and tracking record for any non-CMS-855 or non-CMS-20134 document or activity other than the processing of par agreements, EFT Agreements, Opt-Out Affidavits, Diabetes self-management notices and paramedic intercept contracts. The contractor should track and record all other activities internally.

B. Receipt of Application(s)

1. Acknowledgment of Receipt of Application

The contractor may, but is not required to, send out acknowledgment letters or e-mails.

2. Pre-Screening of Application

The contractor is no longer required to pre-screen provider enrollment applications.

3. Reassignment Packages

In situations where an entity wants to simultaneously enroll a group practice, the individual practitioners therein, and to reassign benefits accordingly, the contractor shall adhere to the instructions contained in the scenarios below. As early in the process as possible, the contractor shall examine the incoming forms to see if a reassignment may be involved; also, the contractor is encouraged (though not required) to have the same analyst handle all three applications in the package.

Only the Form CMS-855Rs are submitted - If a brand new group with new practitioners is attempting to enroll but submits only the Form CMS-855Rs for its group members (i.e., neither the initial Form CMS-855B nor the initial Form CMS-855Is were submitted), the contractor shall develop for the other forms upon receipt and processing.

Only the Form CMS-855R is submitted and a Form CMS 855A or CMS 855B and Form CMS 855I is already on file – Suppose an individual: (1) submits only the Form CMS-855R without including the Form CMS-855A or Form CMS-855B and Form CMS-855I, and (2) indicates on the Form CMS-855R that he/she will be reassigning all or part of his/her benefits to the CAH II. The contractor shall not develop for the other forms if they are

already on file. The Part A/B MAC shall simply process the Form CMS-855R and reassign it to the Form CMS-855A.

Only the Form CMS-855B is submitted - If a brand new group wants to enroll but submits only the Form CMS-855B without including the Form CMS-855Is and Form CMS-855Rs for its group members (i.e., the Form CMS-855B arrives alone, without the other forms), the contractor shall develop for the other forms if they are not submitted upon receipt and processing of the Form CMS-855B.

Only the Form CMS-855I is submitted – Suppose an individual: (1) submits only the Form CMS-855I without including the Form CMS-855B and Form CMS-855R, and (2) indicates on the Form CMS-855I that he/she will be reassigning all or part of his/her benefits to the group practice. The contractor shall develop for the other forms if they are not submitted upon receipt and processing of the Form CMS-855I.

Suppose an individual: (1) submits only the Form CMS-855I, and (2) indicates on the Form CMS-855I that he/she will be reassigning all or part of his/her benefits to an existing Part A CAH II. The contractor shall develop for the CMS-855R if it is not submitted upon receipt and processing of the Form CMS-855I. Upon receipt of the CMS-855R, the contractor shall process the application and reassign the individual to the Part A entity.

Suppose an individual is joining a group that was enrolled prior to the Form CMS-855A or Form CMS-855B (i.e., the group or CAH II never completed a Form CMS-855), the contractor shall develop for a Form CMS-855A from the CAH II or Form CMS-855B from the group. Once the group or CAH II's or group's application is received and processed, the contractor shall process the new reassignment.

C. Application Review and Verification Activities

Unless stated otherwise in this chapter or in another CMS directive. The instructions in this subsection apply to:

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

1. Application Review

Except for situations where a “processing alternative” applies (*see sections 10.3.1(A), 10.3.1(B), 10.3.1(C), 10.3.1(D), 10.3.1(E) and 10.3.2(A) of this chapter*), the contractor shall:

- Ensure that the provider has completed all required data elements on the Form CMS-855, CMS-20134 or Opt-Out Affidavits (including all effective dates) and that all supporting documentation has been furnished. The contractor shall also ensure that the provider has completed the application in accordance with the instructions (1) in this chapter and in all other CMS directives and (2) on the Form CMS-855 or CMS-20134. (The instructions on the Form CMS-855 or CMS-20134

shall be read and applied in addition to, and not in lieu of, the instructions in this chapter and all other applicable CMS directives.)

- Verify and validate all information furnished by the provider on the CMS-855, CMS-20134 or Opt-Out Affidavits, provided that a data source is available.
- Coordinate with State survey/certification agencies and regional offices (ROs), as needed.
- Upon initial enrollment, revalidation, changes of information adding a new individual to the enrollment record and opt-out affidavits, confirm and document that the applicant, all individuals and entities listed on the application, and any names or entities ascertained through other sources, are not presently excluded from the Medicare program by the HHS Office of the Inspector General (OIG) or through the System for Award Management.

The instructions in sections 10.4(C)(1) through 10.4(F) are in addition to, and not in lieu of, all other instructions in this chapter.

2. Review of Paper Applications

a. General Background Information

The contractor shall begin processing the application upon receipt and shall develop for missing certification statements and all other missing information, including application fee, upon review. This includes, but is not limited to (and subject to the processing alternatives *found in Sections 10.3.1(A), 10.3.1(B), 10.3.1(C), 10.3.1(D), 10.3.1(E) and 10.3.2(A) of this chapter*):

- Ensuring that all required data elements on the application have been completed and that all required supporting documentation has been submitted
- Submitted a valid and dated certification statement signed by an appropriate individual (e.g., the enrolling physician for Form CMS-855I applications)
- Validating all data on and submitted with the application, provided that a data source is available
- Entering all information contained on the application into the Provider Enrollment, Chain and Ownership System (PECOS).

The contractor may begin the verification process at any time. Also, the contractor is not required to create a PECOS logging and tracking (L & T) record within a certain specified timeframe (e.g., within 20 days after receipt of the application).

b. Other Guidelines

i. Reenrollment Bar

If the contractor suspects that a provider or supplier is attempting to circumvent an existing reenrollment bar by enrolling under a different business identity or as a different business type, the contractor shall contact their CMS' Provider Enrollment & Oversight Group Business Function Lead (PEOG BFL) for guidance.

ii. State and Country of Birth

The state of birth and country of birth are optional data elements on the Form CMS-855 and CMS-20134. As such, the contractor shall not develop for this information if it was not disclosed on the application and shall not request other contractors to update the PECOS Associate Control (PAC) ID to include this data.

iii. Photocopying Pages

The contractor may accept photocopied pages in any Form CMS-855 or CMS-20134 it receives so long as the application contains a valid signature. For example, suppose a corporation wants to enroll five medical clinics it owns. The section 5 data on the Form CMS-855B is exactly the same for all five clinics. The contractor may accept photocopied section 5 pages for these providers. However, valid signatures must be furnished in section 15 of each application.

iv. White-Out & Highlighting

The contractor shall not write on or highlight any part of the original Form CMS-855 or CMS-20134 application or any supplementary pages the applicant submits (e.g., copy of license). Provider usage of white-out is acceptable, although the contractor should contact the applicant to resolve any ambiguities. In addition, the contractor must determine whether the amount of white-out used on a particular application is within reason. For instance, if an entire application page is whited-out, the contractor should request that the page be resubmitted

3. Review and Processing of Internet-based PECOS Applications

a. General Background Information

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

- The instructions in this section 10.4(C)(3) apply only to Internet-based PECOS applications.
- The instructions in sections 10.4(C)(1) through 10.4(F) of this chapter take precedence over those in this section 10.4(C)(3).

The principal logging and tracking (L & T) statuses for PECOS Internet applications that are not in a final status are:

- Received;

- In Review;
- Returned for Corrections;
- Corrections Received;
- Review Complete; and
- Application in Process.

The submission of a PECOS Internet application will immediately place the L & T record into a “Received” status.

b. *Returns and Certification Statements*

If the contractor can determine (without having yet begun processing the application) that an application can be returned under section 10.4(H)(1) of this chapter (e.g., Form CMS-855I was submitted more than 60 days prior to the effective date), the contractor may return the application without waiting for the arrival of the certification statement.

c. Certification Statement Submitted On Paper or Through E-Signature

Providers and suppliers shall submit an e-signature or submit a certification statement via PECOS upload functionality. No paper certification statements shall be submitted by mail, fax, or scanned e-mail, unless stated otherwise in this chapter or in another CMS directive.

The contractor shall begin processing the application upon receipt and shall develop for missing certification statements and all other missing information, including application fee, upon review. Contractors shall refer to Section 10.4(H)(2) of this manual regarding rejection of an application for non-submission of development.

- If the provider submits an invalid certification statement (e.g., incorrect individual signed it; not all authorized officials signed it), the contractor shall treat this as missing information and shall develop for a correct certification statement using – unless another CMS directive states otherwise - the procedures outlined in this chapter.

i. Certification Statement for Initial PECOS Internet Applications

For initial PECOS Internet applications (as the term “initial” is defined in Section *10.5 of this chapter*), *it is necessary that all Authorized Officials (AOs) provide dated signatures with the application.*

ii. Certification Statement for Change of Information Applications Submitted Via Internet – Based PECOS

For Internet-based PECOS changes of information (as the term “changes of information” is defined in Section *10.5 of this chapter*), if the certification statement is signed by an individual who is not on file

with the contractor as being an authorized or delegated official of the provider, the contractor may accept the certification statement but shall develop for information on the person in question in accordance with *Sections 10.3.1(A), 10.3.1(B), 10.1(C), 10.3.1(D), 10.3.1(E) and 10.3.2(A) of this chapter.*

d. Switch to “In Review” and Application Returns

After – and only after - it receives and accepts the provider’s certification statement, the contractor shall: (1) enter the date of the signature into the “Certification Date” box in the L & T record, and (2) change the L & T status to “Review Complete.” The contractor shall begin processing the application upon receipt and shall develop for missing certification statements and all other missing information, including application fee, upon review.

After changing the L & T status to “In Review,” the contractor shall review the Application Data Report (ADR), and shall commence all applicable validation activities identified in this chapter. (The ADR is only available for printing when the L & T record is in one of the following statuses: “In Review,” “*Received*,” “*Review Complete*,” “Returned for Corrections,” or “Corrections Received.”)

e. Transferal of Data into PECOS

Once the contractor ties the L & T record to the enrollment record, the contractor shall begin the process of transferring the data into PECOS by accepting or rejecting the various data elements. The contractor shall note that: (1) it cannot undo any transfer of information into PECOS, and (2) once the L & T *status is changed to ‘Review Complete’*, the application cannot be returned to the provider for corrections.

f. Miscellaneous Instructions

NOTE: The contractor is advised of the following:

- **Deletion of Erroneous Record** - The contractor shall only delete an erroneously created L & T record by: (1) moving the L & T record to a status of “Rejected,” and (2) using an L & T status reason of “Deleted.”
- **Gatekeeper/Enrollment Screens** - The Gatekeeper and Enrollment screens are only used in the case of Form CMS-855 or CMS-20134 initial enrollment PECOS Internet submissions.
- **Post-Processing Recordkeeping** - After processing a particular PECOS Internet transaction, the contractor shall maintain in the provider’s file: (1) a copy of the final version of the ADR, (2) all submitted certification statements and applicable supporting documents, and (3) documentation of all contacts with the provider (e.g., phone calls, e-mails) per section 10.6.19(H) of this chapter.
- **State Agencies** - In situations described in this chapter in which the contractor is required to submit a copy of the provider’s paper Form CMS-855 to the state agency, the contractor shall send a copy of the

ADR in lieu of the Form CMS-855 if the provider sent in its application via the Internet.

4. Verification - General

a. Means of Verification

Unless stated otherwise in this chapter or in another CMS directive, the contractor shall verify and validate – via the most cost-effective methods available - all information furnished by the provider on or with its application, provided a data source is available. The general purpose of the verification process is to ensure that all of the data furnished on the Form CMS-855 or CMS-20134 is accurate.

Examples of verification techniques include, but are not limited to:

- Site visits
- Third-party data validation sources
- State professional licensure and certification Web sites (e.g., medical board sites)
- Federal licensure and certification Web sites (if applicable)
- State business Web sites (e.g., to validate “doing business as” name)
- Yellow Pages (e.g., to verify certain phone numbers)

The list of verification techniques identified in this section 10.4(C) is not exhaustive. If the contractor is aware of another means of validation that is as cost-effective and accurate as those listed, it is free to use such means. However, all Social Security Numbers (SSNs) and National Provider Identifiers (NPIs) listed on the application will continue to be verified through PECOS. The contractor shall not request an SSN card or driver’s license to verify an individual’s identity or SSN.

b. Procedures

Unless stated otherwise in this chapter or in another CMS directive, the following principles apply:

- (1) A data element is considered “verified” when, after attempting at least one means of validation, the contractor is confident that the data is accurate. (The contractor shall use its best judgment when making this assessment.)
- (2) The contractor need only make one verification attempt (i.e., need only use one validation technique) before either:
 - (a) Requesting clarifying information (as described in sections 10.4(D) through 10.4(F)) if the data element cannot be verified. (However, the contractor is encouraged to make a second attempt using a different validation means prior to requesting clarification.)

OR

(b) Concluding that the furnished data is accurate.

c. Concurrent Reviews

If the contractor receives multiple Form CMS-855 or CMS-20134s for related entities, it can perform concurrent reviews of similar data. For instance, suppose a chain home office submits initial Form CMS-855As for four of its chain providers. The ownership information (sections 5 and 6) and chain home office data (section 7) is the same for all four providers. The contractor need only verify the ownership and home office data once; it need not do it four times – once for each provider. However, the contractor shall document in each provider's file that a single verification check was made for all four applications.

For purposes of this requirement: (1) there must be an organizational, employment, or other business relationship between the entities, and (2) the applications must have been submitted within a few weeks of each other. As an illustration, assume that Group Practice A submits an initial Form CMS-855B on January 1. Group Practice B submits one on October 1. Section 6 indicates that Joe Smith is a co-owner of both practices, though both entities have many other owners that are not similar. In this case, the contractor must verify Mr. Smith's data in both January and October. It cannot use the January verification and apply it to Group B's application because: (1) the applications were submitted nine months apart, and (2) there is no evidence that the entities are related.

d. Contacting Other Contractor

During the verification process, the contractor may need to contact another Medicare contractor for information regarding the provider. The latter contractor shall respond to the former contractor's request within three business days absent extenuating circumstances.

5. Verification Processing Alternatives

Special processing rules (“processing alternatives”), found in *Sections 10.3.1(A), 10.3.1(B), 10.1(C), 10.3.1(D), 10.3.1(E) and 10.3.2(A) of this chapter*, are intended to reduce the burden on contractors and providers while simultaneously maintaining the integrity of the enrollment process. These provisions take precedence over all other instructions outlined in this chapter 10.

Proof of Life Documentation

In the event an enrollment record is updated to reflect an erroneous date or report of death, the contractor shall request documentation that supports “proof of life” (e.g., Retirement, Survivors, and Disability Insurance document issued by SSA). In the event a provider/supplier is unable to obtain such documentation, the contractor shall submit a request to their Provider Enrollment Oversight Group (PEOG) Business Function Lead (BFL) containing the provider/supplier's name, date of birth and SSN so that CMS can confirm proof of life with SSA.

D. Requesting Missing/Clarifying Data/Documentation (Development)

The procedures in sections 10.4(D) are subject to the processing alternatives found in *Sections 10.3.1(A), 10.3.1(B), 10.1(C), 10.3.1(D), 10.3.1(E) and 10.3.2(A) of this chapter.*

1. Development Requests

When requesting missing/clarifying information/documentation and/or or requesting a valid certification statement, the contractor shall adhere to the following:

2. Only One Request Needed

This is the only request the contractor must make. The contractor should, of course, respond to any of the provider's telephone calls, e-mails, etc., resulting from the request. Yet the contractor need not – on its own volition – make an additional request unless the contractor uncovers missing data (or data that must be clarified) that it failed to detect prior to sending the original development letter.

To the extent possible, the contractor should avoid contacting the provider for missing/clarifying data/documentation until it has attempted to validate all of the data on the application. This will obviate the need to contact the provider each time the contractor discovers an issue.

3. Commencement of Timeframe

The 30-day clock referred to above commences on the day on which the contractor, as applicable: (1) mails, faxes, or e-mails the letter/request, or (2) sends the aforementioned Internet-based PECOS e-mail.

4. Telephonic Requests

Unless otherwise stated in this chapter or in another CMS directive, telephonic requests for missing/clarifying data/documentation are generally not permitted for paper or Internet-based PECOS applications; it is important that requests for information or clarification be formalized in writing. However, in cases where CMS permits telephonic requests for such data, the contractor shall adhere to the following:

- A telephonic request is made when the contractor: (1) speaks with an appropriate provider official, or (2) leaves a message either with an appropriate official's staff (e.g., his/her executive assistant) or with an appropriate official's voice mail service. In situation (2), the contractor shall leave the name and telephone number of an appropriate individual at the contractor site who the official can contact; otherwise, the contact does not qualify as a legitimate request for clarification.
- When leaving a message, the contractor shall also state that the requested data/clarification must be furnished within 30 days.
- Telephone requests shall be made on weekdays between 9 am and 5 pm of the provider's time zone.

- The 30-day clock begins on the day (1) of the telephone conversation with the appropriate official, or (2) the message is left.

5. Inability to Contact Provider

If the contractor cannot, for the reasons listed below, communicate with the provider to request information/documentation, it shall attempt one alternative means of communication:

- The mailed letter is returned because the provider is not at that address
- The contractor cannot e-mail the letter to the provider because of issues with the recipient's e-mail system.
- The provider's fax number is repeatedly busy

If an alternative communication also cannot be completed for one of the above reasons, the contractor need not make another attempt to obtain the data and may reject the application once the applicable 30-day period expires. However, it is strongly advised that the contractor make a third attempt to contact the provider prior to taking this step, especially if it appears that the provider is otherwise acting in good faith. (The contractor shall document each attempt to contact the provider.)

(With respect to e-mail, an alternative communication includes sending an e-mail to another listed contact person, delegated official, or authorized official.)

6. Development: Paper Applications

a. Reasons to Develop: Paper Applications

Development is necessary if the provider or supplier:

- Submits an application with at least one missing required data element
- Fails to submit at least one required document
- Submits an invalid certification statement, or
- Writes "N/A" (or a variation thereof) in response to a question that requires a "yes" or "no" answer
- The full application was submitted via fax or email unless the contractor has provided for an exception based on extenuating circumstances
Note: should the contractor instruct the provider/supplier to submit their application via fax or email, the contractor shall inform their PEOG BFL.

Further, development is necessary if the contractor determines that clarification is needed regarding certain information (e.g., particular data cannot be verified or there are data inconsistencies),

b. Elements of a Development Letter

If any of the development reasons above apply, the contractor shall send a development letter to the provider – preferably via e-mail or fax - that contains, at a minimum, the applicable elements in (i) through (vi) below. (See Section 10.7 of this chapter for these model letters)

- i. A list of all of the missing required data/documentation, an explanation of the certification statement's deficiencies, and/or the issues/information to be clarified.
- ii. A request that the provider submits the missing data/documentation, clarification, and/or revised certification statement within 30 calendar days.
- iii. Unless the only data that is missing is documentation, a request that the provider submit an appropriately signed and dated certification statement, which will cover both the submission of any missing data as well as any deficiencies associated with the original certification statement. The certification statement may be submitted by the provider via scanned email, fax or mail (paper submissions only).

(A new certification statement is not required if the only missing material is documentation or if the clarification to be provided does not require any changes to the provider's Form CMS-855 or CMS-20134 application.)
- iv. If missing data is involved, the MAC shall direct the provider or supplier to the CMS Web site at which the CMS-855 or CMS-20134 forms can be found.
- v. A fax number and mailing address to which the missing/clarifying data/documentation/correct certification statement can be sent to the contractor. An email address may be included if applicable.
- vi. The name and phone number of a contact person at the contractor site. An email address may be included if applicable.

7. Development: Internet-Based PECOS Applications

a. Reasons to Develop: Internet-Based PECOS Applications

Development is necessary if the provider or supplier:

- Submits an application with at least one missing required data element
- Fails to submit at least one required document
- Submits an invalid certification statement, or
- Enter "N/A" (or a variation thereof) in response to a question that requires an answer

b. Elements of a Development Request

The contractor may – after switching the L & T status to “Returned for Corrections” - send an e-mail (via PECOS).

When developing for more information, after switching the L & T status to “Returned for Corrections,” the contractor shall send a request to the provider or supplier and may send an email via PECOS containing:

- (i) A list of all missing data/documentation, information to be clarified, and/or certification statement issues;
- (ii) A request that the provider submit the data/materials in question within 30 calendar days; and
- (iii) The name and phone number (an e-mail address is optional) of a contact person at the contractor site.

The contractor shall not attempt to contact the provider for the missing/clarified information and/or valid certification statement prior to sending the e-mail referenced above, though the contractor is free to make a follow-up contact with the provider after sending the e-mail.

E. Receiving Missing/Clarifying Data/Documentation (Response to Development)

The procedures in this section 10.4(E) are subject to the processing alternatives found in *Sections 10.3.1(A), 10.3.1(B), 10.1(C), 10.3.1(D), 10.3.1(E) and 10.3.2(A) of this chapter.*

1. Requirement to Furnish All Missing/Clarifying Material

The provider must furnish all missing/clarifying data/documentation requested by the contractor within the 30-day timeframe. Whether the provider furnished all the information is a decision resting solely with the contractor. Should the provider furnish some (but not all) of the requested data/clarification within the specified time period, the contractor need not contact the provider again to request the remaining information. For instance, suppose the contractor requested missing data in sections 3, 4, and 5 of the Form CMS-855A. The provider only furnished the section 3 data. The contractor may reject the application without attempting another contact.

2. Format of Furnishing Missing Data

a. Paper Applications

Unless stated otherwise in this chapter or in another CMS directive, the provider shall: (1) provide the missing/clarification information (excluding documentation) on the applicable Form CMS-855 or CMS-20134 page(s) and (2) submit the missing material via mail, fax, or scanned e-mail. A newly signed and dated certification statement must accompany the Form CMS-855 or CMS-20134 page(s) containing the missing data – unless the only missing information is supporting documentation, in which case no new certification statement is needed. The certification statement may be submitted by the provider via scanned

email, fax or mail (paper submissions) along with the missing information.

b. Internet-Based PECOS Applications

Unless stated otherwise in this chapter or in another CMS directive, the provider may (1) submit the missing information by entering it into PECOS, (2) submit the missing documentation via fax, e-mail, mail, or the Digital Data Repository (DDR). (The provider may submit the missing data via the applicable paper Form CMS-855 or CMS-20134 pages if it submitted its application via Internet-based PECOS.) The certification statement may be submitted by the provider via scanned email, fax, upload or e-signature along with the missing information.

3. Format of Clarifying Data

In cases where clarifying (as opposed to missing) information is requested, the contractor may accept the clarification by e-mail, fax, or letter. If the provider furnishes the clarification via telephone, the contractor shall – unless another CMS directive states otherwise - request that the provider furnish said clarification in writing (preferably via e-mail).

If the provided clarification ultimately requires the provider to change or alter data that must be reported on the paper CMS-855 or CMS-20134 or PECOS application, the contractor shall instruct the provider via a follow-up e-mail or fax to submit the revised data on the applicable paper CMS-855 or CMS-20134 or PECOS application and to furnish a new certification statement. The provider must submit the revised data and new certification statement within 30 days of the original request for clarification (rather than 30 days from the date of the follow-up request to provide the data via the Form CMS-855 or CMS-20134). The certification statement may be submitted by the provider via scanned email, fax, upload, e-signature or mail (paper submissions) along with the missing information.

Consider the following illustrations:

EXAMPLE 1: The contractor notifies the provider via an e-mailed letter on March 1 of a discrepancy regarding its ownership information on the Form CMS-855A. The provider e-mails the contractor on March 3 and explains the discrepancy. Based on this e-mail, the contractor determines that the provider must correct its ownership data in section 5 of its Form CMS-855A. The contractor sends a follow-up e-mail to the provider on March 7 instructing the provider to do so. The provider must submit the revised data on the Form CMS-855 or CMS-20134 (with a new certification statement) by March 31 (not April 6, or 30 days from the date of the follow-up e-mail).

EXAMPLE 2: The contractor notifies the provider via e-mailed letter on March 1 of a discrepancy regarding its ownership information on the Form CMS-855A. The provider telephones the contractor on March 6 and explains the discrepancy to the contractor's satisfaction. Although the discrepancy does not require the provider to make any revisions to its Form CMS-855A, the contractor shall request that the provider furnish its explanation in writing no later than 30 days from its March 1 e-mail (or March 31), not 30 days from the date of its March 6 request for the written explanation.

EXAMPLE 3: The contractor notifies the provider via e-mailed letter on March 1 of a discrepancy regarding its ownership information on its paper Form CMS-855A. Determining (based on the contractor's e-mail) that the ownership information it provided was incorrect, it submits a revised section 5 of its Form CMS-855A to the contractor with a new certification statement but without any accompanying explanation of the change (e.g., no accompanying letter or e-mail). The contractor receives the revised section 5 on March 12. If the contractor determines that the discrepancy has been resolved via the revised submission, it is not required to contact the provider for an accompanying written explanation. (This is because the clarification was furnished in writing via the CMS-855 or CMS-20134 itself.) If, however, the contractor would like a written explanation or otherwise needs clarification about the submission, it may request that a written explanation be submitted no later than March 31.

4. Maintenance of Received Material

The contractor shall maintain all missing/clarifying information or documentation received (including new certification statements) in the provider file. Storage can be electronic or via hard copy, but it must be in an otherwise easily accessible format.

F. Provider or Supplier Fails to Submit Requested Data/Documentation

The instructions in this section:

- Apply unless another CMS directive or instruction states otherwise.
- Are subject to the processing alternatives found in *Sections 10.3.1(A), 10.3.1(B), 10.1(C), 10.3.1(D), 10.3.1(E) and 10.3.2(A) of this chapter*.

If, in the contractor's view, the provider failed to submit all of the requested data/documentation and/or a valid certification statement (either as a correction to the original certification statement or as part of a request for missing data), the contractor may:

- Reject the application if the 30-day period has elapsed,
- Wait until the 30-day period has elapsed and then reject the application, or
- Extend the 30-day period no more than an additional 30 days if (1) it appears that the provider is making a good-faith effort to comply with the development letter and/or (2) the provider furnished most of the requested data. For instance, suppose the contractor requested 5 pieces of missing information. The provider or supplier timely submitted 4 of them and furnished a signed (though undated) certification statement. Since the provider appears to be acting in good faith, the contractor is encouraged to continue working with the provider.

If the provider fails to fully respond to a second request, the contractor may either: (1) reject the application if the original 30-day period has elapsed, (2) wait until the 30-day period has elapsed and then reject the application, or (3) make a third request using the procedures described above.

G. Application Approvals

1. Non-Certified Suppliers and Individual Practitioners

(This section does not apply to ambulatory surgical centers, portable x-ray suppliers, or providers and suppliers that complete the Form CMS-855A.)

If the contractor approves a supplier's enrollment, it shall notify the applicant via letter of the approval. The letter shall follow the content and format of the model letter in Section *10.7.3 of this chapter*.

Absent a CMS instruction or directive to the contrary, the contractor shall send the approval letter via e-mail, mail or fax within 5 business days of approving the enrollment application in all systems (PECOS, MCS, FISS, VMS). For all applications other than the Form CMS-855S, the letter shall be sent to the supplier's contact person if one is listed; otherwise, the contractor may send the letter to the supplier at the supplier's correspondence address or special payment address.

2. Certified Providers and Certified Suppliers

(This section only applies to: (1) initial Form CMS-855A applications or change of ownership (CHOW), acquisition/merger, or consolidation applications submitted by the new owner; and (2) initial ambulatory surgical center and portable x-ray supplier applications.)

If the contractor decides to recommend approval of the provider or supplier's application, the contractor shall send a recommendation letter to the applicable State agency, with a copy to the Regional Office's (RO) survey and certification unit. The recommendation letter *shall follow the guidance, and use the templates provided, within section 10.7 of this chapter. The contractor may also include an explanation of any special circumstances, findings, or other information that either the State or the RO should know about.*

The letter can be sent to the State/RO via mail, fax, or e-mail.

The contractor shall also:

- Send either a photocopy (not the original), faxed version, or e-mail version of the final completed Form CMS-855 to the State agency or RO (as applicable), along with all updated Form CMS-855 pages, explanatory data, documentation, correspondence, final sales agreements, etc. (which can also be sent via mail, fax, or e-mail). If the CMS-855, associated documentation, and recommendation letter are mailed, they should be included in the same package.

The contractor shall not send a copy of the Form CMS-855 to the RO unless the latter specifically requests it or if the transaction in question is one for which State involvement is unnecessary.

- Notify the applicant that the contractor has completed its initial review of the application. The notification can be furnished via

e-mail, or via the letter identified in Section *10.7.5 of this chapter* (which may be sent to the applicant's contact person). The contractor may, but is not required to, send a copy of its recommendation letter to the provider as a means of satisfying this requirement. However, the contractor should not send a copy to the provider if the recommendation letter contains sensitive information.

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

As stated in 42 CFR §424.57(b), a DMEPOS supplier must, among other things, meet the following conditions to be eligible to receive payment for a Medicare-covered item:

- The supplier has submitted a complete Form CMS-855S, including all supporting documentation, to the National Supplier Clearinghouse (NSC); and
- The item was furnished on or after the date the NSC issued to the supplier a DMEPOS supplier number conveying Medicare billing privileges.
- The date identified in the previous bullet represents the “date of approval.”

4. Medicare Diabetes Prevention Program (MDPP) Suppliers

As stated in 42 CFR §424.205(d), an MDPP supplier must, among other things, not have an ineligible coach on its roster. Though the MDPP supplier's effective date for billing privileges is the date a successful Form CMS-20134 application was submitted, the contractor must notify MDPP suppliers of their application approval, as some MDPP suppliers may not begin furnishing services until receiving such information.

The letter shall follow the content and format of the model letter in Section 10.7.

Absent a CMS instruction or directive to the contrary, the contractor shall send the approval letter within 5 business days of approving the enrollment application in PECOS. The letter shall be sent to the supplier's contact person if one is listed; otherwise, the contractor may send the letter to the supplier at the supplier's correspondence address or special payment address.

For claims submitted by MDPP suppliers prior to the date of enrollment, the contractor shall follow the instructions in Pub. 100-04, chapter 1, section 70, with respect to the claim filing limit. Payments cannot be made for services furnished prior to the date the applicant submitted an application or CAP that resulted in being successfully enrolled.

5. Additional Copies of Approval Letters

With the exception of CMS-855S applications, if any contact person listed on a provider or supplier's enrollment record, requests a copy of a provider

or supplier's Medicare approval letter, the contractor shall send to the contact person via email, fax or mail. This excludes Certification Letters (Tie In notices), as the contractor is not responsible for generating these approvals.

For CMS-855S application approval letters, suppliers may visit https://www4.palmettoga.com/pgx_palmettobacomm/initStatusLetter.do and provide the requested information to receive a copy of the supplier's approval letter.

H. Application Returns, Rejections and Denials

1. Returns

a. Reasons for Return

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

- The applicant sent its paper Form CMS-855 or CMS-20134 to the wrong contractor (e.g., the application was sent to Contractor X instead of Contractor Y).
- The contractor received the *CMS-855 or CMS-20134* application more than 60 days prior to the effective date listed on the application.
- An old owner or new owner in a CHOW submitted its application more than *30* days prior to the anticipated date of the sale. (This applies to Form CMS-855A *and CMS-855B* applications.)
- The contractor can confirm that the provider or supplier submitted an initial enrollment application prior to the expiration of the time period in which it is entitled to appeal the denial of its previously submitted application, or
 - The provider or supplier submitted an initial application prior to the expiration of a re-application bar.
- The provider or supplier submitted an initial application prior to the expiration of a re-enrollment bar.
- The application is to be returned per the instructions in Sections *10.6(A)(3)(j) and 10.6(A)(4) of this chapter*.
- The application is not needed for the transaction in question. Two common examples include:
 - An enrolled physician wants to change his/her reassignment of benefits from one group to another group and submits a Form

CMS-855I and a Form CMS-855R. As only the Form CMS-855R is needed, the Form CMS-855I shall be returned.

- A physician or eligible practitioner who is already enrolled in Medicare submits a Form CMS-855O application, thinking that he must do so in order to refer services for Medicare beneficiaries. The Form CMS-855O can be returned, as the physician is already enrolled via the Form CMS-855I.
- The provider or supplier submitted a revalidation application more than seven months prior to their revalidation due date.
- The MDPP supplier submitted an application with a coach start date more than 30 days in the future.
- A provider or supplier requests that their application be withdrawn prior to or during processing.
- A provider or supplier submits an application that is an exact duplicate of an application that has been processed previously or one that is currently pending processing.
- A provider or supplier submits a paper Form CMS-855 or CMS-20134 application that is outdated (i.e.: a provider submits a Form CMS-855I application that was approved for use in 07/11, which was replaced with the 12/18 version, the 07/11 version shall be returned).
- A rebuttal decision has been issued, therefore the submitted Form CMS-855 or CMS-20134 is not needed.

The contractor shall return the application per the instructions in section 10.4(H)(1) of this chapter.

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

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

b. Procedures for Returning the Application

If the contractor returns the application:

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

- It shall not enter the application into PECOS. No logging & tracking (L & T) record shall be created.
- Any application resubmission must contain a brand new certification statement page containing a signature and date. The provider cannot simply add its signature to the original certification statement it submitted. (This does not apply to e-signature situations.)

If the contractor returns an application, it shall:

- Keep the original application and supporting documents and return a copy,
- Make a copy or scan of the application and documents and return the originals to the provider, or
- Simply send a letter to the provider (in lieu of sending the originals or a copy thereof) explaining that the application is being returned (though not physically returned) and why. If the contractor chooses the third approach and the provider requests a copy of its application, the contractor should fax or mail it to the provider.

c. Other Impacts of a Return

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

A. Expiration of Timeframe for Reporting Changes - If the contractor returns a change of information or CHOW submission per this section 10.4(H)(1) and the applicable 90-day or 30-day period for reporting the change has expired, the contractor shall send an e-mail to its CMS Provider Enrollment & Oversight Group Business Function Lead (PEOG BFL) notifying him or her of the return. PEOG will determine whether the provider's Medicare billing privileges should be deactivated under 42 CFR § 424.540(a)(2) or revoked under 42 CFR § 424.535(a)(1) or (a)(9) and will notify the contractor of its decision.

B. Timeframe Not Yet Expired - If the contractor returns a change of information or CHOW submission and the applicable 90-day or 30-day period for reporting the change has not yet expired, the contractor shall send the e-mail referred to in 10.4(H)(1)(c)(i)(1) above after the expiration of said time period unless the provider has resubmitted the change request/CHOW.

C. Second Return, Rejection, or Denial – If, per 10.4(H)(1)(c)(i)(2), the provider resubmits the change of information or CHOW application and the contractor either returns it again, rejects it per section 10.4(H)(2) of this chapter, or denies it, the contractor shall send the e-mail referred to in (1)(a) above regardless of whether the applicable timeframe has expired. PEOG will determine whether the provider's Medicare billing privileges should be deactivated under 42 CFR § 424.540(a)(2) or revoked under 42 CFR § 424.535(a)(1) or (a)(9) and will notify the contractor of its decision.

ii. Reactivations

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

iii. Revalidations

If the contractor returns a revalidation application per this section 10.4(H)(1), the contractor shall – unless an existing CMS instruction or directive dictates otherwise - deactivate the provider's Medicare billing privileges under 42 CFR §424.540(a)(3) if the applicable time period for submitting the revalidation application has expired. If it has not expired, the contractor shall deactivate the provider's billing privileges after the applicable time period expires unless the provider has resubmitted the revalidation application. If the provider has resubmitted the application and the contractor (1) returns it again, (2) rejects it per section 10.4(H)(2) of this chapter, or (3) denies it, the contractor shall - unless an existing CMS instruction or directive dictates otherwise – deactivate the provider's billing privileges, assuming the applicable time period has expired.

2. Rejections

a. Background

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

- (i) The Form CMS-855, CMS-20134 or Internet-based Provider Enrollment, Chain and Ownership System (PECOS) certification statement: (a) is unsigned; (b) is undated; (c) contains a copied or stamped signature; (d) was signed (as reflected by the date of signature) more than 120 days prior to the date on which the contractor received the application); or (e) for paper Form CMS-855I and Form CMS-855O submissions, someone other than the physician or non-physician practitioner signed the form; or (f) certification statement is missing (paper submission only).
- (ii) The applicant failed to submit all of the forms needed to process a reassignment package within 30 calendar days of receipt.
- (iii) The Form CMS-855 or CMS-20134 was completed in pencil.
- (iv) The wrong application was submitted (e.g., a Form CMS-855B was submitted for Part A enrollment).
- (v) The provider failed to submit an application fee (if applicable to the situation).

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

b. Timeframe

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

c. Incomplete Responses

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

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

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

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

e. Other Impacts of a Rejection

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

A. Expiration of Timeframe for Reporting Changes - If the contractor rejects a change of information or CHOW submission per this section 10.4(H)(2)(e)(i) and the applicable 90-day or 30-day period for reporting the change has expired, the contractor shall send an e-mail to its Provider Enrollment Operations Group Business Function Lead (PEOG BFL) notifying him or her of the rejection. PEOG will determine whether the provider's Medicare billing privileges should be deactivated under 42 CFR

§424.540(a)(2) or revoked under 42 CFR §424.535(a)(1) or (a)(9) and will notify the contractor of its decision.

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

C. Second Rejection, Return, or Denial – If, per (1)(b), the provider resubmits the change of information or CHOW application and the contractor either rejects it again, returns it per section 10.4(H)(2)(e)(i) of this chapter, or denies it, the contractor shall send the e-mail referred to in section 10.4(H)(2)(e)(i) above regardless of whether the applicable timeframe has expired. PEOG will determine whether the provider's Medicare billing privileges should be deactivated under 42 CFR §424.540(a)(2) or revoked under 42 CFR §424.535(a)(1) or (a)(9) and will notify the contractor of its decision.

ii. Reactivations

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

iii. Revalidations

If the contractor rejects a revalidation application per this section 10.4(H)(2)(e)(iii), the contractor shall – unless an existing CMS instruction or directive dictates otherwise - deactivate the provider's Medicare billing privileges under 42 CFR §424.540(a)(3) if the applicable time period for submitting the revalidation application has expired. If it has not expired, the contractor shall deactivate the provider's billing privileges after the applicable time period expires unless the provider has resubmitted the revalidation application. If the provider has resubmitted the application and the contractor (1) rejects it again, (2) returns it per section 10.4(H)(2)(e)(iii) of this chapter, or (3) denies it, the contractor shall - unless an existing CMS instruction or directive dictates otherwise –deactivate the provider's billing privileges, assuming the applicable time period has expired.

f. Additional Rejection Policies

i. Resubmission after Rejection

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

ii. Applicability

Unless stated otherwise in this chapter or in another CMS directive, this section 10.4(H)(1) applies to all applications identified in this chapter (e.g., initial applications, change requests, Form CMS-855O

applications, and Form CMS-588 submissions, change of ownership (CHOW) applications, revalidations, and reactivations).

iii. Physicians and Non-Physician Practitioners

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

iv. Notice

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

v. Copy of Application

If the contractor rejects an application, it shall either (1) keep the original application and all supporting documents, or (2) make a copy or scan of the application and documents and return the originals to the provider. If the contractor chooses the former approach and the provider requests a copy of its application, the contractor may fax or mail it to the provider.

3. Denials

a. Notification Letters for Denials

i. General Requirements

If a Medicare contractor finds a legal basis for denying an application - and, if applicable under section 10.4(H)(3) of this chapter, receives approval from the Provider Enrollment & Oversight Group (PEOG) for said denial - the contractor shall deny the application and notify the provider or supplier by letter. The denial letter shall contain:

- A legal (i.e., regulatory) basis for each reason for the denial;
- A clear explanation of why the application is being denied, including the facts or evidence that the contractor used in making its determination;
- An explanation of why the provider or supplier does not meet the applicable enrollment criteria;
- Procedures for submitting a corrective action plan (CAP, for denials based on 42 CFR §424.530(a)(1)); and
- Complete and accurate information about the provider or supplier's further appeal rights.

ii. Prior PEOG Approval Necessary

For cases involving 42 CFR §424.530(a)(3) (Felony Convictions), §424.530(a)(4) (False or Misleading Information or Application), 42 CFR §424.530(a)(6) (Existing Overpayment at Time of Application), 42 CFR §424.530(a)(12) (Revoked Under Different Name, Numerical Identifier, or Business Identity), 42 CFR §424.530(a)(13) (Affiliation that Poses an Undue Risk), 42 CFR §424.530(a)(14) (Other Program Termination or Suspension) or denials involving MDPP Suppliers, the contractor shall obtain approval of both the denial and the denial letter from PEOG via the ProviderEnrollmentRevocations@cms.hhs.gov mailbox prior to sending the denial letter.

Consistent with §424.530(f), CMS may apply a reapplication bar that prohibits a provider or supplier from enrolling in Medicare for up to 3 years if its enrollment application is denied because the provider or supplier submitted false or misleading information on or with (or omitted information from) its application. PEOG will notify the contractor of its determinations and instruct the contractor as to how to proceed. Absent a CMS instruction or directive to the contrary, the letter shall be sent to the provider or supplier, via certified mail, no later than 5 business days after PEOG concludes that the provider or supplier's application should be denied.

Contractors shall not proceed with finalization of a denial until guidance is received from PEOG. If guidance from PEOG is delayed, contractors shall carve the impacted application(s) out of their timeliness reporting. Contractors shall document and report the impact application in their Monthly Status Reports.

iii. Prior PEOG Approval Unnecessary

When a decision to deny is made, the contractor shall send a letter to the provider identifying the reason(s) for denial and furnishing appeal rights. The letter shall follow the format of those shown in Section [*10.7.8 of this chapter*](#). Absent a CMS instruction or directive to the contrary, the letter shall be sent to the provider or supplier, via certified mail, no later than 5 business days after the contractor concludes that the provider or supplier's application should be denied.

iv. Denial Based Upon Reason Under 42 CFR 424.530

When issuing a denial, the contractor shall insert the appropriate regulatory basis (e.g., 42 CFR § 424.530(a)(1)) into its denial letter. The contractor shall not use provisions from this chapter 10 as the basis for denial. Except as described in section 10.4(H)(3) of this chapter or as otherwise stated in this chapter, the contractor may issue a denial letter without prior approval from CMS' Provider Enrollment & Oversight Group (PEOG) of the denial or the denial letter.

If the applicant is a certified provider or certified supplier and one of the denial reasons listed below is implicated, the contractor need not submit a recommendation for denial to the state/RO. The contractor can simply: (1) deny the application, (2) close out the PECOS record,

and (3) send a denial letter to the provider. The contractor shall copy the state and the RO on said letter.

All denied applications and all applicable denial reasons shall be entered into the Provider Enrollment Chain and Ownership System (PECOS) including fingerprint and non-covered provider or supplier type denials. For non-covered provider or supplier type denials, contractors shall select the “Other” specialty/provider/supplier type option and input the type listed on the application.

v. Denial Reasons

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

The provider or supplier is determined not to be in compliance with the enrollment requirements in subpart P (of Part 424) or on the enrollment application applicable to its provider or supplier type, and has not submitted a plan of corrective action as outlined in 42 CFR part 488. Such non-compliance includes, but is not limited to, the following situations:

- i. The provider or supplier does not have a physical business address or mobile unit where services can be rendered.
- ii. The provider or supplier does not have a place where patient records are stored to determine the amounts due such provider or other person.
- iii. The provider or supplier is not appropriately licensed.
- iv. The provider or supplier is not authorized by the federal/state/local government to perform the services that it intends to render.
- v. The provider or supplier does not meet CMS regulatory requirements for the specialty that it seeks to enroll as. (See section 10.2.7 of this chapter for examples of suppliers that are not eligible to participate.)
- vi. The provider or supplier does not have a valid social security number (SSN) or employer identification number (EIN) for itself, an owner, partner, managing organization/employee, officer, director, medical director, and/or authorized or delegated official.
- vii. The applicant does not qualify as a provider of services or a supplier of medical and health services. (For instance, the applicant is not recognized by any Federal statute as a Medicare provider or supplier (see section 10.2.7 of this chapter)). An entity seeking Medicare payment must be able to receive reassigned benefits from physicians in accordance with the Medicare reassignment provisions in § 1842(b)(6) of the Act (42 U.S.C. 1395u(b)).

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

ix. The provider or supplier does not meet standards specific to their supplier type (e.g., MDPP Supplier standards outlined in 42 CFR §424.205(d)).

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

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

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

The provider or supplier, or any owner, managing employee, authorized or delegated official, medical director, supervising physician, or other health care personnel of the provider or supplier who is required to be reported on the CMS-855 or CMS-20134 is—

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

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

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

- Felony crimes against persons, such as murder, rape, assault, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions.
- Financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the

individual was convicted, including guilty pleas and adjudicated pretrial diversions.

- Any felony that placed the Medicare program or its beneficiaries at immediate risk, such as a malpractice suit that results in a conviction of criminal neglect or misconduct.
- Any felonies outlined in section 1128 of the Social Security Act.

While, as discussed in section 10.4(M)(2)(c) of this chapter, a re-enrollment bar will be established for providers and suppliers whose billing privileges are revoked, this does not preclude the contractor from denying re-enrollment to a provider or supplier that was convicted of a felony within the preceding 10-year period or that otherwise does not meet all of the criteria necessary to enroll in Medicare.

Note that if an MDPP coach is identified as having any of the above felony requirements, this would not constitute a denial under this category for the MDPP supplier, as the coach, not the supplier has the felony charge. The MDPP supplier would, however, have an enrollment denial under non-compliance for having an ineligible coach.

Contractors shall submit all felonies found on CMS-855 and CMS-20134 forms to PEOG for review via the ProviderEnrollmentRevocations@cms.hhs.gov mailbox.

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

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

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

Upon on-site review or other reliable evidence, CMS determines

that the provider or supplier:

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

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

i. Background

Consistent with 42 CFR §424.530(a)(6), an enrollment application may be denied if: (1) the current owner (as that term is defined in 42 CFR §424.502) of the applying provider or supplier (or its owners), or (2) the applying physician or non-physician practitioner, has an existing overpayment that is equal to or exceeds a threshold of \$1,500 and it has not been repaid in full at the time the application was filed.

Specifically,

- (A) The enrolling provider, supplier, or owner (as defined in § 424.502) thereof has an existing Medicare debt.
- (B) The enrolling provider, supplier, or owner (as defined in §424.502) thereof was previously the owner of a provider or supplier that had a Medicare debt that existed when the latter's enrollment was voluntarily terminated, involuntarily terminated, or revoked, and all of the following criteria are met:
 - (1) The owner left the provider or supplier with the Medicare debt within 1 year before or after that provider or supplier's voluntary termination, involuntary termination or revocation.
 - (2) The Medicare debt has not been fully repaid.
 - (3) CMS determines that the uncollected debt poses an undue risk of fraud, waste, or abuse.

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

- (a) The amount of the Medicare debt.
- (b) The length and timeframe that the enrolling provider, supplier, or owner thereof was an owner of the prior entity.
- (c) The percentage of the enrolling provider, supplier, or owner's ownership of the prior entity.
- (d) Whether the Medicare debt is currently being appealed.
- (e) Whether the enrolling provider, supplier, or owner thereof was an owner of the prior entity at the time the Medicare debt was incurred.

ii. A denial of Medicare enrollment under paragraph (a)(6) can be avoided if the enrolling provider, supplier or owner thereof does either of the following:

- (a) Satisfies the criteria set forth in § 401.607 and agrees to a CMS-approved extended repayment schedule for the entire outstanding Medicare debt; or

(b) Repays the debt in full.

iii. Contractor's Determination of Overpayment

The contractor shall abide by the following:

- a. When processing a Form CMS-855A, CMS-855B, CMS-855S or CMS-20134 initial or change of ownership application, determine – using a system generated monthly listing – whether the applicant or any of the owners listed in section 5 or 6 of the application has an existing or delinquent Medicare overpayment.
- b. When processing a Form CMS-855I initial application, determine – using a system generated monthly listing – whether the physician or any non-physician practitioner has an existing or delinquent Medicare overpayment.

If an owner, physician, or non-physician practitioner has such an overpayment, the contractor shall deny the application, using 42 CFR §424.530(a)(6) as the basis. However, prior approval from CMS' Provider Enrollment & Oversight Group (PEOG) is required before proceeding with the denial. The contractor shall under no circumstances deny an application under §424.530(a)(6) without receiving PEOG approval to do so.

c. Consider the following examples:

Example #1: Hospital X has a \$200,000 overpayment. It terminates its Medicare enrollment. Three months later, it reopens as Hospital Y and submits a new Form CMS-855A application for enrollment as such. A denial is not warranted because §424.530 (a)(6) only applies to physicians, practitioners, and owners.

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

Example #3 - Same scenario as example #2, but assume that his new practice is an LLC of which he is only a 30 percent owner. A denial is not warranted because the provision applies to owners and, again, the \$50,000 overpayment was attached to him.

Example #4 - Jane Smith is a nurse practitioner in a solo practice. Her practice ("Smith Medicine") is set up as a closely-held corporation, of which she is the 100 percent

owner. Smith Medicine is assessed a \$20,000 overpayment. She terminates her Medicare enrollment. Nine months later, she submits a Form CMS-855I application to enroll herself, Jane Smith as a new individual provider. The business will be established as a sole proprietorship. A denial is not warranted because the \$20,000 overpayment was attached to Smith Medicine, not to Jane Smith.

d. Excluded from denial under §424.535(a)(6) are individuals or entities (1) on a Medicare-approved plan of repayment or (2) whose overpayments are currently being offset or being appealed.

e. The contractors shall also observe the following:

1. In determining whether an overpayment exists, the contractor need only review its own records; it need not contact other contractors to determine whether the person or entity has an overpayment in those contractor jurisdictions.

2. The instructions in this section 10.4(H)(3) apply only to (1) initial enrollments, and (2) new owners in a change of ownership.

3. The term “owner” under section §424.502 means any individual or entity that has any partnership interest in, or that has 5 percent or more direct or indirect ownership of the provider or supplier as defined in sections 1124 and 1124A(A) of the Act)

4. If the person or entity had an overpayment at the time the application was filed but repaid it in full by the time the contractor performed the review described in this section 10.4(H)(3), the contractor shall not deny the application based on 42 CFR §424.530(a)(6).

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

The provider, supplier or any owning and managing employee or organization of the provider or supplier has been placed under a Medicare or Medicaid payment suspension at the time the denial is issued, as defined in §405.370 through §405.372.

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

An HHA submitting an initial application for enrollment:

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

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

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

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

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

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

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

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

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

- 1. A physician or eligible professional's Drug Enforcement Administration (DEA) Certificate of Registration to dispense a controlled substance is currently suspended or revoked; or
- 2. The applicable licensing or administrative body for any State in which a physician or eligible professional practices has suspended or revoked the physician or eligible professional's ability to prescribe drugs, and such suspension or revocation is in effect on the date the physician or eligible professional submits his or her enrollment application to the Medicare contractor.

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

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

- Owning and managing organizations and individuals (regardless if the organizations or individuals are disclosed on the CMS-855 or CMS-20134 application);
- Geographic location;
- Provider or supplier type;
- Business structure; or
- Any evidence that the two parties (the revoked provider or supplier and newly-enrolling provider or supplier) are similar or that the provider or supplier was created to circumvent the revocation or re-enrollment bar.

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

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

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

An affiliation is defined as:

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

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

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

- The provider or supplier is currently terminated or suspended (or otherwise barred) from participation in a state Medicaid program or any other federal health care program; or
- The provider or supplier’s license is currently revoked or suspended in a state other than that in which the provider or supplier is enrolling. In determining whether a denial is appropriate, CMS considers the following factors:
 - The reason(s) for the termination, suspension, or revocation,
 - Whether, as applicable, the provider or supplier is currently terminated or suspended (or otherwise barred) from more than one program (for example, more than one State’s Medicaid program), has been subject to any other sanctions during its participation in other programs or by any other State licensing boards or has had any other final adverse actions (as that term is defined in § 424.502) imposed against it, and
 - Any other information that CMS deems relevant to its determination.

NOTE: With respect to (a)(14), PEOG -- rather than the contractor – will make all determinations regarding whether a provider or supplier has an termination or suspension from another program.

vi. Post-Denial Submission of Enrollment Application

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

- If the initial denial was not appealed, the provider or supplier’s appeal rights have lapsed, or
- If the initial denial was appealed, the provider or supplier has received notification that the determination was upheld, or
- The reapplication bar has expired, if applicable.

Contractors shall return an application that is submitted before these have occurred.

vii. 30-Day Effective Date of Denial

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

As stated in 42 CFR §424.530(c), if the denial was due to adverse activity (e.g., exclusion, felony) of an owner, managing employee, an

authorized or delegated official, medical director, supervising physician, or other health care personnel of the provider or supplier furnishing Medicare services, the denial may be reversed, with PEOG approval, if the provider or supplier submits proof that it has terminated its business relationship with that individual or organization within 30 days of the denial notification.

b. Other Impacts of a Denial

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

A. Expiration of Timeframe for Reporting Changes

If the contractor denies a change of information or CHOW submission per this section 10.4(H)(3) and the applicable 90-day or 30-day period for reporting the change has expired, the contractor shall send an e-mail to the

MedicareProviderEnrollment@cms.hhs.gov mailbox notifying PEOG of the denial. PEOG will determine whether the provider's Medicare billing privileges should be deactivated under 42 CFR §424.540(a)(2) or revoked under 42 CFR §424.535(a)(1) or (a)(9) and will notify the contractor of its decision.

B. Timeframe Not Yet Expired

If the contractor denies a change of information or CHOW submission and the applicable 90-day or 30-day period for reporting the change has not yet expired, the contractor shall send the e-mail referred to in 10.4(H)(3)(b)(i)(A) above after the expiration of said time period unless the provider has resubmitted the change request/CHOW.

C. Second Rejection, Return, or Denial

If, per 10.4(H)(3)(b)(i)(B), the provider resubmits the change of information or CHOW application and the contractor either denies it again, returns it per section 10.4(H)(1) of this chapter, or rejects it per section 10.4.8.2 of this chapter, the contractor shall send the e-mail referred to in 10.4(H)(3)(b)(i)(A) above regardless of whether the applicable timeframe has expired. PEOG will determine whether the provider's Medicare billing privileges should be deactivated under 42 CFR §424.540(a)(2) or revoked under 42 CFR §424.535(a)(1) or (a)(9) and will notify the contractor of its decision.

ii. Reactivations

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

iii. Revalidations

If the contractor denies a revalidation application per this section 10.4(H)(3), the contractor shall – unless an existing CMS instruction or directive dictates otherwise - deactivate the provider's Medicare

billing privileges if the applicable time period for submitting the revalidation application has expired. If it has not expired, the contractor shall revoke the provider's billing privileges after the applicable time period expires unless the provider has resubmitted the revalidation application. If the provider has resubmitted the application and the contractor (1) denies it again, (2) returns it per section 10.4(H)(1) of this chapter, or (3) rejects it per section 10.4(H)(2) of this chapter, the contractor shall - unless an existing CMS instruction or directive dictates otherwise – revoke the provider's billing privileges, assuming the applicable time period has expired.

4. Provider Enrollment Appeals Process – Denials

For more information regarding the provider enrollment appeals process, see Section *10.6.18 of this chapter*.

I. Terminations – Voluntary and Involuntary

1. Voluntary Terminations of Certified Providers and Suppliers

Regulations in 42 CFR §489.52, a provider of services may terminate its agreement with CMS. Voluntary terminations shall be processed in accordance with the timeframes in section 10.4(I), et al. of this chapter.

a. If the termination involving a certified provider or supplier is received via a CMS-855 application (paper or electronic application), the contractor shall deactivate the entity per their request as a voluntary termination in the Provider Enrollment Chain and Ownership System (PECOS) and notify the provider or supplier. Within 3 business days of processing the termination, the contractor shall notify the State Agency (SA) and Regional Office (RO) of the action via e-mail. The termination date of certified providers and suppliers must not be more than 6 months from the date the notice is filed, according to 42 CFR §489.52(b)(2). Contractors shall consult the appropriate RO should a certified providers and supplier submit a termination date more than 6 months from the date the notice is filed.

If the contractor is setting a termination effective date that is less than 6 months in the future, contractors shall consider the availability of other facilities in the area and not unduly disrupt the services to the community or otherwise interfere with the effective and efficient administration of the health insurance program. Contractors shall consult the appropriate RO for assistance when these situations arise.

b. If a certified provider or supplier submits a voluntary termination request via letter to the RO or SA, the RO or SA will terminate the provider agreement and issue a termination letter to the certified provider or supplier. The RO or SA will copy the contractor on the letter. The contractor shall deactivate the certified provider or supplier as a voluntary termination in the PECOS based on the letter.

Within 3 business days of processing the termination, the contractor shall notify the RO and SA of the termination via e-mail.

c. If the SA does not renew a certified provider or supplier's license to operate, the SA will inform the contractor of the termination of the license.

Contractors shall take revocation actions for non-compliance as directed in Section 10.4(M) of this chapter.

If the certified provider or supplier decides not to renew their state license to operate, the SA will inform the contractor of the termination of the license. The contractor shall notify the provider in writing, stating that the provider should submit an application to voluntary terminate their enrollment and billing privileges. The letter must state that the provider must take action, but if no action is taken, the provider's enrollment and billing privileges will be deactivated. The enrollment shall be deactivated as a voluntary termination in PECOS and the contractor shall notify the certified provider or supplier. The contractor shall also notify the RO and SA via e-mail within 3 business days after processing the termination action.

d. A tie-out will not be issued to the contractors in the previous situations. If the provider is notified by the RO or SA, the contractor will be copied or if the contractor receives a voluntary termination, the contractor will process the deactivation and notify the RO and/or SA. There is no need for additional communication following these activities.

e. According to 42 CFR §489.52(b)(3), the effective date of voluntary termination is the date business ceased providing services to the community. If a retroactive termination date is requested, this is permissible, provided there were no Medicare beneficiaries receiving services from the facility on or after the requested termination date (contractor s shall confirm this via a claims review prior to approving the retroactive termination). If claims were submitted, contractors shall reach out to the provider to confirm that services were indeed rendered and adjust the term date with the provider, if no adjustment is made or contact cannot be made, an overpayment request must be issued.

f. Upon receipt of a voluntary termination for a certified providers or suppliers, the contractor may ask the provider or supplier to complete the "Special Payments" portion of section 4 of the Form CMS-855 or CMS-20134 so that future payments can be sent thereto. The addition should be included in the same transaction as the termination (i.e., one transaction incorporating both items). If the provider or supplier wants to change its existing special payments address, the transaction should be treated as a separate change request (i.e., one termination and one change request). The provider or supplier is not required to submit a Form CMS-588 in conjunction with a termination.

2. Voluntary Terminations of Non-certified Suppliers

Voluntary terminations shall be processed in accordance with the timeframes Section *10.5 of this chapter*.

- a. When processing a voluntary termination of a non-certified supplier, the contractor shall only accept the request via application (form CMS-855 or the equivalent electronic application via Internet-Based PECOS). Non-certified suppliers cannot submit a termination request via letter.
- b. When processing a voluntary termination of a reassignment, the contractor shall contact the group to confirm that: (1) the group member

PTAN is being terminated from all locations; and (2) if multiple group member PTANs exist for multiple group locations, each PTAN is terminated. However, if a group has one PTAN with multiple addresses, the contractor need not contact the group to confirm the termination.

- c. When processing a voluntary termination of a reassignment, the contractor shall terminate non-certified suppliers effective the day after the supplier requests in its termination application.
- d. Upon receipt of a voluntary termination of certified or non-certified providers or suppliers, the contractor may ask the provider or supplier to complete the “Special Payments” portion of section 4 of the Form CMS-855 or Form CMS-20134 so that future payments can be sent thereto. If the provider or supplier has no special payments address already on file, the addition should be included in the same transaction as the termination (i.e., one transaction incorporating both items). If the provider wants to change its existing special payments address, the transaction should be treated as a separate change request (i.e., one termination and one change request). The provider is not required to submit a Form CMS-588 in conjunction with a termination.

3. Involuntary Terminations

a. Tie-Out Notice

If the contractor receives a tie-out notice from the RO that involuntarily terminates the provider or supplier’s Medicare participation because the provider or supplier no longer meets the conditions of participation, the contractor need not send a letter to the provider or supplier notifying it that its Medicare participation has been terminated. The RO will issue such a letter and afford appeal rights. The contractor shall adhere to the instructions in section 10.4(M)(2)(b)(i) of this chapter with respect to revoking the provider or supplier’s enrollment, as the provider or supplier is no longer in compliance with Medicare enrollment regulations. **NOTE:** The contractor must identify in its revocation letter the exact provision within said statute(s)/regulation(s) that the provider/supplier is not in compliance with.

The revocation shall be recorded in PECOS using the status reason of “Non-Compliance: Provider/Supplier Type Requirements Not Met.” Contractors shall not identify the involuntary termination action in PECOS as a Deactivation with a status reason of “Voluntarily Withdrawal from the Medicare Program.”

b. Revocation Letter

In addition, contractor shall issue a revocation letter to the certified provider or supplier using 42 CFR §424.535(a)(1), as the legal basis for the revocation. The letter shall also contain the effective date of the revocation, appeal rights and the length of the enrollment bar as determined by CMS and indicated to the contractor. The issuance of the Tie-Out for non-compliance of CMS enrollment requirements, conditions of participation, or conditions of coverage is sufficient to revoke.

c. State Agency Site Survey Results

If the SA performs a site survey as a result of a complaint or cessation of business and finds the certified provider or supplier has vacated the practice location and is no longer operational, the SA will notify the contractor. The contractor shall send a notice, located in Section 10.7.2 of this chapter, to the certified provider or supplier requesting that they: (1) provide evidence to the contractor and SA showing they are still operational, (2) submit a request to the contractor to voluntarily terminate their enrollment or (3) submit a request to the contractor to update their enrollment information (e.g. change in practice location). The SA and RO shall be copied on the notice. Certified providers and suppliers shall be given 10 days to respond to the request.

If the certified provider or supplier is operational, they must provide evidence to support their position to the contractor with a copy to the SA. The SA will conduct a review and a new survey within 15 days of receiving the certified provider or supplier's evidence. The SA will forward the outcome to the contractor with a copy to the RO. The contractor shall not take any action until they receive notification from the SA. If only the contractor receives a response from the provider or supplier, the contractor shall notify the RO. The RO will notify the SA that a second site survey should be performed, if the provider has indicated that it is open and operational or issue a voluntary termination if the provider or supplier has indicated they are no longer operational.

If the certified provider or supplier submits a CMS-855 application to terminate their enrollment to the contractor, they shall process the termination in PECOS and notify the certified provider or supplier. The contractor shall notify the RO and SA via e-mail within 3 business days after processing the termination action.

If the certified provider or supplier submits a CMS-855 application to change their enrollment information, the contractor shall process the change and inform the SA, via e-mail, that a survey of the new practice location is required once the change is processed, in accordance with Section 10.3.1(A) of this chapter.

If the certified provider or supplier does not respond to the contractor's request, the contractor shall deactivate the enrollment as a voluntary termination in PECOS and notify the certified provider or supplier. The contractor shall notify the RO and SA, via e-mail, within 3 business days after processing the termination action.

4. Additional Information

For more information on voluntary terminations, refer to:

- Section 1866(b)(1) of the Social Security Act
- 42 CFR 489.52(b)
- Pub. 100-07, chapter 3, section 3046 (SOM)

J. Changes of Information

Unless indicated otherwise, the instructions in sections 10.4(J) through 10.4(J)(7) of this chapter apply to Part A and Part B enrollments.

Unless otherwise specified in this chapter or another CMS directive, if an enrolled provider is adding, deleting, or changing information under its existing tax identification number, it must report the change using the applicable Form CMS-855 or CMS-20134. Letterhead is not permitted.

The provider shall (1) furnish the changed data in the applicable section(s) of the form, and (2) sign and date the certification statement. In accordance with 42 CFR §424.516(d) and (e), the timeframes for providers to report changes to their Form CMS-855 or CMS-20134 information are as follows:

1. Changes of Information: Complete Form CMS-855 or CMS-20134 Applications

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

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

If the provider fails to submit a complete application within the aforementioned 30-day period, the contractor shall follow the instructions in section 10.4(H)(2) of this chapter.

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

- Processing the complete application consistent with the timeframes for initial applications in Section *10.5 of this chapter*.
- Ensuring that all data elements on the Form CMS-855 or CMS-20134 have been validated, as it would with an initial enrollment application. The contractor shall not approve the change request until all data on the complete Form CMS-855 or CMS-20134 has been validated.
- Creating an L & T record and enrollment record in PECOS prior to approving the change request. (The receipt date should be the date on which the complete application was received, not the date on which the initial change request was received.) The transaction

should be treated as an initial enrollment in PECOS; internally, the contractor shall treat it as a change of information. As the complete application will presumably incorporate the changed data reported on the original Form CMS-855 or CMS-20134 change request, the contractor shall not take two separate counts (one initial and one change request) for the transaction.

2. Requirements for a Provider or Supplier to Report Changes of Information Via a Form CMS-855 or Form CMS-20134 Application

a. Information a Provider or Supplier Must Report Within 30 Days

Pursuant to 42 CFR 424.516(d), changes of information requirements apply to physicians and non-physician practitioners and physician and non-physician practitioner organizations (i.e.: clinic/group practices).

For these provider types, the following changes must be reported within 30 days:

- A change of ownership
- Adverse legal action
- A change in practice location

Suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS); and

Independent diagnostic testing facilities (IDTFs):

For these providers/suppliers, the following changes must be reported within 30 days:

Any change of ownership or control, including a change in an authorized or delegated official.

All other informational changes involving the providers listed in this section 10.4(J)(2)(a) must be reported within 90 days.

b. Information a Provider or Supplier Must Report Within 90 Days

Pursuant to 42 CFR 424.516(e), change of information requirements apply to the following providers and suppliers:

All providers and suppliers other than those listed in section 10.4(J)(2)(a) above.

3. Additional Guidance Concerning Specific Changes of Information

- **Application Signatures** - If the signer has never been reported in section 6 of the Form CMS-855 or CMS-20134, section 6 must be completed in full with information about the individual. (This policy applies regardless of whether the provider already has a Form CMS-855 or CMS-20134 on file.) The contractor shall ensure that all validation required to be performed with respect to the individual is conducted.

- **Notifications** – For changes of information that do not require Regional Office approval (e.g., Form CMS-855I changes; Form CMS-855B changes not involving ambulatory surgical centers or portable x-ray suppliers; minor Form CMS-855A changes), the contractor shall (1) furnish written, e-mail, or fax confirmation to the provider that the change has been made, and (2) document (per Section *10.7 of this chapter*) in the file the date and time the confirmation was made. If, however, the transaction only involves an area code/ZIP Code change, it is not necessary to send confirmation to the provider that the change has been processed.

a. Change in Practice Location Address

In cases where a provider submits a Form CMS-855 or Form CMS-20134 request to change its practice location address, the contractor shall contact the location currently associated with the provider in the Provider Enrollment, Chain and Ownership System (PECOS) or the Multi-Carrier System (MCS) to verify that the provider is no longer there and did in fact move.

b. Change in Special Payments Address

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

When processing a revalidation or Form CMS-855 or Form CMS-20134 reactivation application, the contractor shall – unless another CMS directive instructs otherwise – abide by the instructions in subsections 10.4(J)(3)(a) and 10.4(J)(3)(b) above, respectively, if the (a) practice location address or (b) special payment address on the application is different than that which is currently associated with the provider in PECOS or MCS.

c. Provider or Supplier Changing Specialty Type

With the exception of individual physicians, providers or suppliers (including non-physician practitioners) who wish to change their enrolled provider or supplier type must deactivate their current enrollment and submit an initial enrollment application (screening and an application fee applies as applicable).

4. Incomplete or Unverifiable Changes of Information

The contractor shall follow the instructions in this section 10.4(J)(4) if a submitted change request cannot be processed to completion.

a. Unresponsive Providers or Unverifiable Changes

If Provider has an established enrollment record in the Provider Enrollment, Chain and Ownership System (PECOS) assume that a provider with a PECOS enrollment record submits a Form CMS-855 or CMS-20134 change request and (1) fails to timely respond to the contractor's request for additional or clarifying information, or (2) the changed information cannot be validated. The contractor shall reject the change request in accordance with section 10.4(H)(2) of this chapter. Moreover, if the changed information is of such materiality that the contractor cannot determine whether the provider still meets all enrollment requirements, the contractor shall refer the matter to its Provider Enrollment Oversight Group (PEOG) Business Function Lead (BFL) for guidance. Examples include but are not limited to:

- change in the provider's lone practice location,
- change in ownership, or
- change in EFT information.

5. Change of EFT Information

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

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

a. Timeframe for Regional Office (RO) Approval

In situations where RO approval of the change of information is required, it is strongly recommended that the contractor advise the provider that it may take up to 6 months (or longer) for the request to be approved. The manner and timing in which this information is relayed lies solely within the contractor's discretion.

b. Post-Recommendation Changes

If an applicant submits a change request after the contractor makes a recommendation on the provider's initial CMS-855 application but before the RO issues a tie-in/approval notice, the contractor shall process the newly-submitted data as a separate change of information; it shall not take the changed information/corrected pages and, immediately upon receipt, send them directly to the State/RO to be incorporated into the existing application. The contractor, however, need not enter the change request into the Provider Enrollment, Chain and Ownership System (PECOS) until the tie-in notice is issued.

In entering the change request into PECOS, the contractor shall use the date it received the change request in its mailroom as the actual receipt date in PECOS; the date the tie-in notice was issued shall not be used. The contractor shall explain the situation in the “Comments” section in PECOS and in the provider file.

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

i. Verifying Distance Requirements with the CMS Regional Offices

Regulations found at 42 CFR 485.610(e)(2) and in the State Operations Manual (SOM), Pub. 100-07, Chapter 2, Section 2256H state that the CAH’s provider-based location must meet certain distance requirements from the main campus of another hospital or CAH.

The MAC shall reach out to the appropriate CMS Regional Office (RO) Division of Survey and Certification (DSC) during the processing of the CMS-855A for a verification that the CAH’s new provider-based location is more than 35 miles (15 miles in the case of mountainous terrain or an area with only secondary roads) from the main campus of another hospital or CAH. The MAC’s recommendation of approval cannot be made without receiving a response from the RO DSC.

If the RO DSC finds that CAH’s new provider-based location meets the distance requirements, the RO DSC will send a response to the MAC stating this. When this communication is received, the MAC shall continue processing as usual, up through issuing a recommendation of approval to the appropriate RO and/or State Agency (SA).

If the RO DSC responds that the new provider-based location does not meet the distance regulations, the MAC shall issue the rejection letter found *in Section 10.7.7(C) of this chapter* to the CAH. The application shall be rejected in PECOS.

The CAH will be provided three options by the RO DSC if it does not meet the distance requirements:

1. The CAH keeps the new provider-based location, which will cause an involuntary termination in 90 days (as outlined in the State Operations Manual, Pub. 100-07, Chapter 3, Section 3012).
2. The CAH will terminate the new provider-based location and continue their enrollment as a CAH.
3. The CAH keeps the new provider-based location, but converts to a hospital (as outlined in the State Operations Manual, Pub. 100-07, Chapter 2, Sections 2256G and 2256H).

For each of these options, the MAC will keep the CAH’s enrollment in an approved status in PECOS. In the case of option (a) above, the MAC will receive a tie-out notice for termination, which will lead to revocation of the CAH’s enrollment. For option (b), the CAH’s enrollment remains approved and the MAC shall expect no further

communication from the RO DSC. If the CAH chooses option (c) to convert to a hospital, the MAC will receive a CMS-855A to terminate the CAH's enrollment and a new CMS-855A to enroll as a hospital.

7. Additional Reporting Requirements for IDTFs and DMEPOS Suppliers

Additional reporting requirements for IDTFs can be found in 42 CFR §410.33(g)(2) and in section 10.2(I)(2) of this chapter. Reporting requirements for DMEPOS suppliers can be found in 42 CFR §424.57(c)(2).

K. Revalidation of Providers and Suppliers

The contractor shall follow the guidance provided in sections 10.4(K) through 10.4(K)(15) when processing revalidation applications, unless indicated otherwise in another CMS directive. Also, this guidance takes precedence over all others instructions in this chapter *10* with respect to revalidation processing unless, again, another CMS directive specifies otherwise.

Consistent with section 6401(a) of the Patient Protection and the Affordable Care Act (ACA), all existing providers and suppliers are required to revalidate their enrollment information under new enrollment screening criteria. Providers and suppliers are normally required to revalidate their Medicare enrollment every 5 years (every 3 years for suppliers of Durable Medical Equipment, Prosthetics Orthotics and Supplies (DMEPOS)). However, CMS reserves the right to perform off-cycle revalidations as deemed necessary.

1. Revalidation Lists

The CMS will identify the providers and suppliers required to revalidate during each cycle. CMS will communicate when new lists become available through the appropriate channels, at which time the contractor shall obtain the list from the CGI Share Point Ensemble website.

The list will contain a suggested revalidation due date, consisting of a month and day of the year, to assist contractors in staggering their workload and distributing the e-mails or mailings evenly. Contractors shall review the list and may alter a provider/suppliers' due date month based on staffing levels and workload. However, the day that the revalidation is due shall always remain as the last day of each month (i.e., June 30th, July 31st, or August 31st). When distributing the workload, contractors shall ensure that the revalidation due dates are divided equally over a 7-month period and accounts for fifty percent of the contractor's list (i.e., 50 percent of the revalidation due dates are defined in the first 7 months, and the remaining 50 percent in the last 7 months). Contractors shall also ensure that the due dates selected do not go beyond the current year.

Once the contractor confirmed lists are received by CMS, a final list will be generated capturing the provider/supplier's due date and timeframes for each revalidation action (i.e., e-mail or mail date, pend, deactivation). The list will be posted to the CGI Share Point Ensemble site and will be refreshed with updated enrollment data every 60 days to account for providers/suppliers who have been deactivated or have had changes in the provider/supplier's enrollment information. Contractors shall use the most current list available to conduct their e-mails or mailings and shall allow sufficient time for the

provider/supplier to meet their deadline (between 90 to 105 days prior to the revalidation due date).

This list will also be made available on <https://data.cms.gov/revalidation> so that providers and suppliers are aware of who has been selected to revalidate.

2. Mailing Revalidation Letters

Based on the due date identified on the list, contractors shall send a revalidation notice between 90 to 105 days prior to the revalidation due date using the sample letter provided in Section *10.7.15 of this chapter*. The initial revalidation letter may include a generic provider enrollment signature; however, development letters shall include a provider enrollment analyst's name and phone number for provider/supplier contacts.

Contractors may send revalidation notices via email if this option is in line with the Contractor's security requirements and capabilities. Email addresses will be provided as part of the CMS list (derived from Section 2 and 13 of PECOS). When sending revalidation notices via email, contractors shall indicate "URGENT: Medicare Provider Enrollment Revalidation Request" in the subject line to differentiate this from other emails. The sample letter provided in Section *10.7.15 of this chapter* should be included in the body of the email and should not be included as an attachment to the email or require a password be sent to the provider/supplier to view the email content. Contractors are not required to send a paper copy of the revalidation notice if sent via email. If the notice is sent to multiple email addresses but one is returned as undeliverable, contractors are not required to mail a revalidation notice as long as one email is delivered successfully.

If all of the emails are returned as undeliverable, paper revalidation notices shall be mailed to the provider/supplier's correspondence and special payment addresses, within the 90 to 105 day timeframe prior to the revalidation due date. If the correspondence and special payment address is the same, contractors shall send the second letter to the provider/supplier's practice location address. If the correspondence, practice and special payments address are the same, only one letter shall be sent.

If no email addresses exist in the enrollment record or the contractor chooses the mail option, contractors shall mail two revalidation notices to the provider/supplier's correspondence and special payment address and/or practice location address using the instructions outlined above.

When issuing revalidation notices to individual group members, contractors shall provide on the revalidation notice identifying information of the organization (s) (i.e., Legal Business Name (LBN), Doing Business As (DBA) name, Tax Identification Number) that the provider reassigns benefits in lieu of including the provider's PTANs. Individual group members may be more familiar with the LBN or DBA name of the organizations they are associated versus the PTANs. This should eliminate contractors developing for PTANs not included on the revalidation application.

If one of the locations is found to be incorrect or the letter gets returned as undeliverable, the contractor shall re-send the returned letter to an address not used for the initial mailing. If it is determined that all locations are the same and the contractor has exhausted all reasonable means of contacting the provider/supplier, the contractor shall deactivate the provider/supplier's enrollment in either MCS/FIIS or PECOS, whenever possible.

3. Non-Response to Revalidation Actions

a. Phone Calls

Contractors may continue to contact providers/suppliers via telephone or email to communicate non-receipt of revalidation applications; however, these contacts are not required.

If telephone or email contacts are made, contractors shall continue to document all communications with the providers/suppliers.

b. Pend Status

Contractors shall apply the payment hold (pend flag) in PECOS if the provider/supplier fails to respond to the revalidation request. MACs shall perform this action within 25 days after the revalidation due date.

Contractors may, but are not required to notify the provider/supplier of the payment hold.

Since there is no way to assign a payment hold to an individual group member without it preventing payment to the entire group, contractors shall issue a letter to the individual group members in lieu of the payment hold within 25 days after the revalidation due date using the sample letter provided in Section *10.7.15(F) of this chapter* (Revalidation Past Due Group Member Sample Letter). Contractors may send the payment hold notice via email if this option is in line with the contractor's security requirements and capabilities. Email addresses will be provided as part of the CMS list (derived from Section 2 and 13 of the Provider Enrollment Chain and Ownership System (PECOS). When sending payment hold notices via email, contractors shall indicate "URGENT: Revalidation Past Due" in the subject line to differentiate this from other emails. The letter should be included in the body of the email and should not be included as an attachment to the email or require a password be sent to the provider/supplier to view the email content. Contractors are not required to send a paper copy of the payment hold notice if sent via email. If the notice is sent to multiple email addresses but one is returned as undeliverable, contractors are not required to mail a payment hold notice as long as one email is delivered successfully.

If all of the emails are returned as undeliverable, paper payment hold notices shall be mailed to the provider/supplier's correspondence and special payment addresses. If the correspondence and special payment address is the same, contractors shall send the second letter to the provider/supplier's practice location address. If the correspondence, practice and special payments address are the same, only one letter shall be sent.

If no email addresses exist in the enrollment record or the contractor chooses the mail option, contractors shall mail the two payment hold notices to the provider/supplier's correspondence and special payment address and/or the practice location address using the instructions outlined above.

This requirement shall only apply to individual group members who are reassigned to a group and/or providers who have employment arrangements.

c. Deactivation Actions

Contractors shall deactivate a provider/supplier's enrollment record for failure to respond to the revalidation request between days 60 – 75 after the revalidation due date and notify the provider/supplier using the sample letter provided in Section *10.7.15(E) of this chapter*. (Model Revalidation Deactivation Letter).

The contractor shall establish the effective date of deactivation as the same date the action is being taken.

If an individual provider is deactivated for failure to respond to a revalidation request, the contractor shall search the provider's associate record to determine if the provider is identified as a supervising physician on any independent diagnostic testing facility (IDTF) enrollments. If so, the provider shall be disassociated as the supervising physician for that entity. If the deactivated provider is the only supervising physician on file for the IDTF, the contractor shall develop for an active supervising physician to bring the IDTF into compliance. The contractor shall give the IDTF 30 days to respond. Failure to provide an active supervising physician in the designated timeframe shall result in revocation of the IDTF's billing privileges for non-compliance with the IDTF standards.

4. Receipt of Revalidation Application

Contractors shall return all unsolicited applications. Unsolicited applications are: (1) revalidation applications received more than 7 months prior to the provider/suppliers established due date and/or (2) Providers and suppliers identified as TBD (To Be Determined) on the revalidation look up tool. Contractors shall return these applications using the sample return letter template provided in Section *10.7.15(H) of this chapter*, within 20 business days of receipt. Contractors shall also submit a request to CMS to have the application fee returned to the provider.

Revalidation applications submitted within 7 months of their due date shall be accepted and processed by the contractor. The submission date of a revalidation application for providers/suppliers who are on the CMS posted list will not alter their future revalidation due date. The contractor may only accept revalidation applications signed by the individual provider or the authorized official (AO) or delegated official (DO) of the provider/supplier organization.

If a provider/supplier wishes to voluntary withdrawal from Medicare (including deactivating all active PTANs), the contractor shall accept this request via phone, U.S. mail or fax from the individual provider or the AO/DO (on letterhead); the contractor shall not require the provider/supplier to complete a CMS-855 or CMS-20134 application. If the request is made via telephone, the contractor shall document the telephone conversation (in accordance with section 10.6.19(I) of this chapter) and take the appropriate action in PECOS.

Any branch that has a separate provider agreement (e.g., home health agency (HHA)) it must revalidate on a separate Form CMS-855A. It cannot revalidate via the main provider's Form CMS-855A. If the branch has a separate CMS Certification Number (CCN) but not a separate provider

agreement (e.g., hospital psychiatric unit, HHA branch), the revalidation can be disclosed on the main provider's Form CMS-855A. This is because the branch is a practice location of the main provider and not a separately enrolled entity. Separate fees are not required.

If the provider/supplier requests to collapse its PTANs as a result of revalidation, the contractor shall process those requests, if appropriate (based on payment localities, etc.).

5. Revalidation Application Received and Development Required

If the revalidation application is received but requires development (i.e., missing application fee, hardship request, reassignments and/or employment arrangements, documentation, signature, etc.), the contractor shall notify the provider or supplier via mail, phone, fax or email. Contractors shall develop for all of the missing information in one development request. Providers and suppliers shall be given 30 days to respond to the contractor's request and may submit the missing information via mail, fax, or e-mail containing scanned documentation (this includes missing signatures and dates). The provider may submit a full 855I or sections 1, 2, 4, & 15 of the 855I to report the missing reassignments and/or employment arrangements any time prior to their revalidation due date, even post revalidation application approval.

If licensure and/or educational requirements (i.e., non-physician practitioner's degree or diploma) can be verified online, the contractor shall not require the provider/supplier to submit this documentation. If the supporting documentation currently exists in the provider's file, the provider or supplier is not required to submit that documentation again with their revalidation application. The contractor may utilize the existing documentation for verification. Residency information shall also not be required as part of revalidation. The contractor shall not require further development for data that is missing on the provider/supplier's revalidation application if the information is disclosed (1) elsewhere on the application, or (2) in the supporting documentation submitted with the application with the exception of the following items:

- Adverse legal action data
- Legal business name (LBN)
- Tax identification number (TIN)
- NPI-legacy number combinations
- Supplier/Practitioner type
- "Doing business as" name
- Effective dates of sale/transfer/consolidation or indication of acceptance of assets/liabilities

Contractors shall not require providers/suppliers to include the PTAN(s) in section 2 or 4 on the revalidation application, provided they have included the necessary information (NPI, TIN, LBN, DBA, etc.) for the contractors to

appropriately make the association. If the PTAN is not submitted but is needed to make the connection, contractors shall use the shared systems, PECOS or their provider files as a resource before developing back to the provider/supplier.

Contractors shall not develop for the EFT form if the provider/supplier has the **most current** version of CMS 588 (EFT) on file. If an EFT form is submitted along with a bank letter or voided check, contractors may verify that the LBN matches and develop to process the application accordingly.

If the supporting documentation currently exists in the provider's file, the provider or supplier is not required to submit that documentation again during the enrollment process. The contractor shall utilize the existing documentation for verification. Documentation submitted with a previously submitted enrollment application, or documentation currently uploaded in PECOS, qualifies as a processing alternative, unless stated otherwise in this chapter or any CMS directive. In addition, per section **10.6.19(I)** of this chapter, the contractor shall document in the provider file that the missing information was found elsewhere in the enrollment package, with previously submitted applications or documentation currently uploaded in PECOS. This excludes information that must be verified at the current point in time (i.e. a license without a primary source verification method). Additionally, contractors shall not utilize information submitted along with opt-out applications for enrollment application processing or vice-versa.

In scenarios where a revalidation response is received for a single reassignment within an enrollment record that has multiple reassessments and/or employment arrangements, the contractor shall develop to the contact person (or the individual provider if a contact is not listed), for the remaining reassessments and/or employment arrangements not accounted for. If no response is received within 30 days, the contractor shall revalidate the single reassignment and deactivate the reassessments and/or employment arrangements within the enrollment records that were not revalidated.

The deactivation date shall be consistent with the latter of: (1) the revalidation due date, or (2) the date deactivation action is taken due to non-response or incomplete response to a development request for all provider and supplier business structures (i.e. organizations, sole proprietors, sole owners, etc.).

To illustrate, in scenario #1 the contractor issues a revalidation notice to the provider and includes reassessments and/or employment arrangements for Groups A, B & C. The provider submits the revalidation application to the contractor but only addresses the reassignment for Group A. The contractor develops to the contact person for the missing reassessments and/or employment arrangements for Groups B & C. The provider responds with the reassignment information for Groups B & C prior to the development due date. Since the revalidation application is still considered in progress, the provider may submit a full 855I or sections 1, 2, 4, & 15 of the 855I to report the missing reassignment information, even post revalidation application approval. The revalidation application is processed to completion and the provider experiences no break in billing.

In scenario #2 the contractor issues a revalidation notice to the provider and includes reassignments and/or employment arrangements for Groups A, B & C. The provider submits the revalidation application to the contractor but only addresses the reassignment for Group A. The contractor develops to the contact person for the missing reassignments and/or employment arrangements for Groups B & C. No response is received within 30 days and the revalidation due date has passed.

Group A's reassignment is revalidated. Group B & C's reassignments and/or employment arrangements are deactivated effective with the date deactivation action is taken due to non-response or incomplete response to a development request. The approval letter issued by the contractor will identify the reassignments and/or employment arrangements that were revalidated and those terminated with the effective date of the reassignment or termination. The provider is required to submit a full application (CMS-855R) to reactivate the reassignment. The effective date for the reactivation is based on the receipt date of the CMS-855R. In this scenario the provider does experience a break in billing.

In this scenario, the entire enrollment shall not be deactivated; only the non-response reassignments and/or employment arrangements shall be deactivated and the other reassignments and/or employment arrangements revalidated.)

If other missing information is not received within 30 days, contractors shall deactivate the provider/supplier within 25 days after the development due date and notify the provider/supplier of the deactivation using the sample letter provided in Section *10.7.15(E) of this chapter*. After deactivation, the provider shall be required to submit an entirely new application in order to reactivate their PTANs. Supporting documentation received may be used, if needed, for subsequent application submissions.

6. Revalidation Received after a Pend is Applied

The contractor shall remove the pend within 15 business days of receiving the revalidation application, even though the submitted application has not been processed to completion. This will release all held paper checks, SPRs, and EFT payments.

The contractor shall process the revalidation application using current processing instructions and mail, fax, or email a decision letter to the provider or supplier to notify it that the revalidation application has been processed.

7. Revalidation Received After a Deactivation Occurs

Contractors shall require the provider/supplier to submit a new full application to reactivate their enrollment record after they have been deactivated. The contractor shall process the application as a reactivation. The provider/supplier shall maintain their original PTAN but the contractor shall reflect a gap in coverage (between the deactivation and reactivation of billing privileges) on the existing PTAN using Action Reason (A/R) codes in the Multi-Carrier Claims System (MCS) based on the receipt date of the application. The provider will not be reimbursed for dates of service in which they were not in compliance with Medicare requirements (deactivated

for non-response to revalidation). Group members whose reassignment association was terminated when the group was deactivated shall be reactivated with the group enrollment. The effective dates assigned to the reassigned providers should align with the group's effective date per standard reactivation instructions.

Since the issuance of PTANs and effective dates for Part A certified providers/suppliers, including ASC's and Portable X-Ray, are determined by the RO and the deactivation action does not terminate their provider agreement, contractors shall allow the provider/supplier to maintain its original PTAN and effective date when the reactivation application is processed.

When processing the revalidation application after a deactivation occurs, the contractor shall not require any provider/supplier whose PTAN(s) have been deactivated to obtain a new State survey or accreditation as a condition of revalidation

8. Change of Information Received Prior to or After the Revalidation Letter is Mailed

If a change of information (COI) application is received from the provider/supplier prior to the contractor having mailed the revalidation letter, the contractor shall process the COI as normal and proceed with mailing the revalidation notice.

If the provider/supplier submits an application marked as a revalidation but only includes enough information to be considered a COI, the contractor shall (1) develop for a complete application containing the missing data elements, and (2) treat it as a revalidation.

If a change of information (COI) application is received after the contractor has mailed the revalidation notice, the contractor shall (1) develop for a complete application containing the missing data elements, and (2) treat it as a revalidation.

9. Reassignments and/or Employment Arrangement Applications Received After Revalidation Letter Mailed

If the revalidation due date has been posted (7 months prior to revalidation due date) and a reassignment and/or employment arrangement application has been received within that 7 month timeframe, contractors shall process the reassignment and/or employment arrangement application. The newly established reassignment/employment arrangement is not required to be reported on the revalidation application and contractors shall not develop for the missing information, since they were established after the revalidation notice was issued. Contractors shall however, maintain the reassignment/employment arrangement information in the enrollment record when processing the revalidation application and this information shall not be overridden. In the instance where the provider or supplier fails to respond to the revalidation request, all reassessments/employment arrangements shall be end dated, including the newly established reassignment/employment arrangement.

To illustrate, Dr. Doe submits a CMS-855R application to his contractor to add a new reassignment to Browns Medical Center. Soon after he checks <https://data.cms.gov/revalidation> and notices that he is due for revalidation in the next 7 months. He submits his revalidation application to his contractor but does not include the reassignment for Browns Medical Center since it is in progress and an approval notification has not been issued. The contractor finalizes the reassignment changes and then proceeds with processing the revalidation application. The contractor shall not develop for the new reassignment to Browns Medical Center and shall maintain the reassignment in the provider's enrollment record when processing the revalidation application.

If a revalidation and change of information application is received concurrently, the contractors shall merge the two applications and process accordingly.

10. Revalidating Providers Involved in a Change of Ownership (CHOW)

Contractors shall not take revalidation actions on providers or suppliers that are undergoing a CHOW that is currently in process by the contractor or pending review by the State/RO. Contractors shall notify their Provider Enrollment Oversight Group (PEOG) Business Function Lead (BFL) if a seller enrollment record is up for revalidation and the CHOW application is currently in process by the contractor. Contractors shall include the seller and buyer enrollment record ID in their email notification to their PEOG BFL.

11. Large Group Revalidation Coordination

In addition to providing the finalized revalidation list with contractor confirmed due dates, CMS will provide a list of large groups affected by this notification, including the individual providers reassigning benefits to their group that appear on the 7 month list. Contractors may stagger the large group mailings however they see fit to ensure the group receives notification that providers within their group will be receiving a request to revalidate in the next 7 months. Contractors shall send the notification letter to the Authorized/Delegated Official or the enrollment contact person. Contractors may send the group notices via email utilizing the email addresses provided as part of the CMS list (derived from Section 2 and 13 of PECOS).

Contractors shall indicate **“IMPORTANT: Group Notification of Upcoming Provider Enrollment Revalidation Request”** in the subject line to differentiate this from other emails. Contractors shall use the sample letter provided in Section *10.7.15(C) of this chapter* to notify the large groups by attaching the letter in the body of the email. The letter should not be included as an attachment to the email or require a password be sent to the provider/supplier to view the email content. Contractors are not required to send a paper copy of the group notice if sent via email. If all of the emails the notice is sent to are returned as undeliverable, paper revalidation notices shall be mailed to the provider/supplier's correspondence and special payment addresses, within the 90 to 105 day timeframe. Contractors do not need to mail a notification if one or a few of the emails are returned as undeliverable, but one or more have been delivered successfully. If the correspondence and special payment address is the same, contractors shall

send the second letter to the provider/supplier's practice location address. If the correspondence, practice and special payments address are the same, only one letter shall be sent.

If no email addresses exist in the enrollment record, then contractors shall mail the notice to the group's correspondence address.

Contractors shall include with the notification letter a spreadsheet identifying the individual providers that will be revalidated. The spreadsheet shall contain the Provider's Name, National Provider Identifier (NPI) and Specialty. This information will be provided as part of the list supplied by CMS.

The large group list will contain only those large groups consisting of 200 or more reassessments. Groups with less than 200 reassessments will not appear on the list and are not required to be emailed or mailed a group notification letter; however, all reassignment information will be available at <https://data.cms.gov/revalidation> for providers and suppliers to view.

Contractors shall designate an enrollment analyst for each of the large groups to coordinate revalidation activities. The designated enrollment analyst shall be identified on the group notification letter. The enrollment analysts shall work directly with the group's enrollment contact person or the Authorized/Delegated Official on file.

Contractors shall allow large groups to submit a spreadsheet identifying those providers that are no longer practicing at their group in lieu of submitting CMS-855R termination applications. The spreadsheet shall be accompanied by a letter signed by the Authorized/Delegated Official of the group. This process is only acceptable for large groups who are completing their revalidation and coordinating directly with the contractor.

12. Finalizing the Revalidation Application

Prior to processing the revalidation application to completion, the contractor shall ensure that:

- A site visit (if applicable to the provider/supplier in question) is requested to be conducted by the National Site Visit Contractor (NSVC)
- The provider/supplier meets all applicable federal regulatory requirements regarding licensure, certification and/or educational requirements, as listed in the Code of Federal Regulations (CFR) and as described in CMS Publication 100-02 for his or her supplier type.
- The provider/supplier's information is revalidated based on the information in PECOS.
- Practice locations continue to be verified; however, there is no need to contact each and every location separately. Verification shall be done with the contact person listed on the application and noted accordingly in the contractor's verification documentation per section 10.4(C) of this chapter.

- The appropriate logging & tracking (L&T) record type and finalization status are identified in PECOS.
- An enrollment record is not marked as revalidated in PECOS if responses have been received for some PTANs yet not all PTANs have been addressed (meaning that no action has been taken on the non-response PTANs, i.e., end-dated). If all PTANs have been addressed (i.e., revalidated, end-dated), the enrollment can be marked as revalidated.
- PECOS and the claims systems remain in sync. The contractor shall not directly update the shared systems without first updating PECOS when processing a revalidation unless instructed otherwise in another CMS directive.
- When processing of the revalidation application is complete, contractors shall issue an approval letter to the contact person or the provider/supplier if a contact person is not listed, via mail, fax, or email. If the provider/supplier has reassessments that were terminated due to non-response, the approval letter shall contain the reassessments that were terminated due to non-response and the effective date of termination (i.e., the revalidation due date or the development due date).

13. Revalidation Reporting

Contractors are no longer required to submit reports on the 5th and 20th of each month for Cycle 2. However, contractors shall maintain internally the method of delivery for the provider/supplier revalidation notices and the date the email or letter was sent. CMS may periodically request ad hoc reporting of this data. The data elements for ad-hoc reporting shall include, but is not limited to the following; revalidation notification delivery date, delivery method, delivery address, deactivation date, provider response date, reactivation date, application finalization date, etc.

14. Revalidation Files Available Online

The revalidation due dates are available at <https://data.cms.gov/revalidation> via the Revalidation look up tool. The tool includes all enrolled providers/suppliers. Those due for revalidation will display a revalidation due date, all other providers/suppliers not up for revalidation will display a “TBD” (To Be Determined) in the due date field. In addition, a crosswalk to the organizations that the individual provider reassess benefits will also be available at <https://data.cms.gov/revalidation> on the CMS website.

15. Revalidation Extension Requests

Contractors shall only accept extension requests from a provider or supplier that was not given the full seven months advance notice prior to their revalidation due date as a result of the due date list being untimely posted to the CMS website. Contractors shall no longer accept extension requests from the providers or suppliers for any other reason.

If there is a delay in posting the above referenced list, which impacts a provider or supplier receiving the full seven month advance notice, the

contractor shall accept the provider or supplier's extension request and grant the provider or supplier an extension up to the full seven month period from the date of the list being posted with no impacts to their effective date. contractors shall accept these type of extension requests from the provider or supplier and the requests may be made by the provider or supplier in writing (fax/email permissible) or via phone requested by the individual provider, Authorized/Delegated Official or contact person.

L. Reactivations

1. Form CMS-855 or CMS-20134 Reactivations

a. Limited

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

b. Moderate

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

c. High

Form CMS-855 or Form CMS-20134 reactivation applications submitted by providers and suppliers in the "high" level of categorical screening shall be processed in accordance with the screening procedures for this category. A site visit will therefore be necessary prior to the contractor's final decision regarding the application.

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

If the contractor approves a provider or supplier's reactivation application for a Part B non-certified supplier, the reactivation effective date shall be the date the contractor received the application that was processed to completion. Also, upon reactivating billing privileges for a Part B non-certified supplier, the contractor shall issue a new Provider Transaction Access Number (PTAN).

Contractors shall grant retrospective billing privileges in accordance with Section 10.6.2(E) for reactivating providers and suppliers, unless otherwise stated in this chapter. This includes providers that were deactivated for not responding to a revalidation request.

3. CMS 855A Certified Provider or Supplier Reactivations

With the exception of HHAs, reactivation of Medicare billing privileges does not require a new State survey or the establishment of a new provider agreement or participation agreement. Per 42 CFR § 424.540(b)(3)(i), an

HHA must undergo a new State survey or obtain accreditation by an approved accreditation organization before its billing privileges can be reactivated. (See section 10.2.1(F)(10) of this chapter for more information.)

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

To reactivate its billing privileges, a provider or supplier deactivated for failing to timely notify the contractor of a change of information must submit a complete Medicare enrollment application.

5. Reactivations – Miscellaneous Policies

a. Deactivated for longer than one year

In any situation, described either herein or otherwise, if a *non-certified* provider or supplier is deactivated for longer than one year the provider or supplier is ineligible for reactivation and must complete an application for initial enrollment. An application fee will be assessed as applicable.

b. Previous Withdrawn Status

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

c. Deactivation for Non-Billing

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

d. Reactivation Applications: Contractor Timeliness Standards

For Form CMS-855 or CMS-20134 reactivation applications, the timeliness requirements in Section *10.5 of this chapter*, pertaining to initial enrollment applications apply. The contractor shall – unless a CMS instruction directs otherwise - validate all of the information on the application just as it would with an initial application.

M. Revocations

1. Revocations: Background and General Requirements

a. Introduction

Medicare revokes currently enrolled providers and suppliers Medicare billing privileges and corresponding provider/supplier agreements pursuant to the federal regulations at 42 CFR §424.535. A Medicare revocation is a “termination” as defined at 42 CFR §455.101.

Revocation of Medicare billing privileges will not impact a provider or supplier's ability to submit claims to non-Medicare payers using their National Provider Identifier.

If the contractor determines that a provider or supplier's billing privileges should be revoked or receives information from PEOG that a provider or supplier's billing privileges should be revoked, it shall undertake activities to process the revocation, apply the revocation in PECOS, notify the provider, and afford appeal rights. This section includes, but is not limited to, information concerning the contractor's responsibilities to:

- Preparing a draft revocation letter;
- E-mailing the letter to PEOG via the EnrollmentEscalations@cms.hhs.gov mailbox with additional pertinent information regarding the basis for revocation;
- Receiving PEOG's determinations and abiding by PEOG's instructions regarding the case;
- If PEOG authorizes the revocation:
 - Revoking the provider's billing privileges back to the appropriate date;
 - Establishing the applicable reenrollment bar;
 - Updating PECOS to show the length of the reenrollment bar;
 - Assessing an overpayment, as applicable; and
 - Sending the revocation letter, affording appeal rights, to the provider or supplier via certified mail.

b. Administrative Requirements

This subsection addresses the contractor's administrative requirements pertaining to revocations including time frames, writing revocation draft letters, and seeking PEOG approval prior to sending a determination letter to a provider. Information concerning elements of a revocation and applying a revocation are covered in subsequent subsections.

c. Processing Revocations: Timeframe for Processing of Revocation Actions

If the contractor receives approval from PEOG (or receives an unrelated request from PEOG) to revoke a provider or supplier's billing privileges, the contractor shall complete all steps associated with the revocation no later than 5 business days from the date it received PEOG's approval/request. The contractor shall notify PEOG that it has completed all of the revocation steps no later than 3 business days after these steps have been completed.

d. Notification Letters for Revocations

i. General Information

When a Medicare contractor discovers a basis for revoking a provider or supplier's enrollment under 42 CFR §424.535 - and, if applicable under section 10.4(M) of this chapter, receives approval from PEOG for the revocation - the contractor shall revoke billing privileges and notify the provider or supplier by letter. The revocation letter shall contain:

- A legal (i.e., regulatory) basis for each reason for revocation;
- A clear explanation of why Medicare billing privileges are being revoked, including the facts or evidence that the contractor used in making its determination;
- An explanation of why the provider or supplier does not meet the applicable enrollment criteria;
- The effective date of the revocation (see section 10.4(M)(2)(i)) of this chapter for more information);
- Procedures for submitting a CAP (if revoked under 42 CFR §424.535(a)(1)); and
- Complete and accurate information about the provider or supplier's further appeal rights.

ii. Revocation Letter: One Letter Per Enrollment

A contractor shall issue a unique revocation letter per enrollment. For example, regarding revocation letters for solely owned organizations, when revoking Medicare billing privileges for a physician/non-physician practitioner and their solely owned organization, contractors shall issue **two** revocation letters; one for the individual and the other for the solely owned organization. One letter shall not be issued to convey revoked Medicare billing privileges for both the individual and the solely owned organization.

iii. Elements of a Revocation Letter - General

When drafting a revocation letter the contractor includes the following elements:

- Effective date
- Revocation Reason

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

- Reenrollment Bar information
- Information regarding the provider/supplier's appeal rights

iv. Requirements for CMS PEOG's Approval of Revocation Letters

The contractor shall determine, based upon the guidance in this subsection (below) whether to submit its draft revocation letter to CMS' Provider Enrollment Oversight Group (PEOG) for approval, prior to sending such a letter to a provider.

A. When PEOG Approval of Revocation Letter is Necessary

Except as described above and in section 10.4(M)(1)(d)(iv)(2), the contractor shall submit draft revocation letters to the EnrollmentEscalations@cms.hhs.gov mailbox for PEOG to review. PEOG will notify the contractor of the outcome of this review and instruct the contractor how to proceed. The contractor shall obtain PEOG approval prior to sending a revocation letter.

PEOG reviews a contractor's draft revocation letter for technical correctness and to make determinations including, but not limited to, (1) the extent to which the revoked provider's or supplier's other locations are affected by the revocation, (2) the geographic application of the reenrollment bar, and (3) the effective date of the revocation.

The contractor may not alter an approved revocation letter. Altering an approved revocation letter requires submitting the altered letter for a fresh review via the process described above.

The contractor shall not proceed with finalizing the revocation until guidance is received from PEOG. If guidance from PEOG is delayed, contractors shall carve the impacted application(s) out of their timeliness reporting. Contractors shall document and report the impact application in their Monthly Status Reports.

B. When PEOG Approval of Revocation Letter is Unnecessary

The contractor need not obtain prior PEOG approval of the revocation and the revocation letter if the revocation involves any of the following situations:

- §424.535(a)(1) - Situation (a), (c), (d), (e), (g), (h), or (i)
- §424.535(a)(6)
- §424.535(a)(11)

v. Issuing the Revocation Letter to the Provider/Supplier

The contractor shall send revocation letters by USPS Certified Mail.

The contractor shall not send an initial revocation letter via e-mail, but it is acceptable to e-mail a copy of the letter subsequent to the original issuance via USPS Certified Mail.

The contractor shall make sure the letter is dated and mailed on the same business day.

2. Elements of a Revocation

This section addresses elements of a revocation used in a revocation notification letter.

a. Effective Date of a Revocation

Revocation effective dates are based upon the revocation reason. The contractor shall apply an effective date to a revocation based upon the federal regulation at 42 CFR §424.535(g). This regulation requires a Medicare revocation to have an effective date that is either prospective or retroactive.

A prospective revocation becomes effective 30 days after CMS or the CMS contractor mails notice of its determination to the provider or supplier. A retroactive revocation becomes effective on a date that is the same as the effective date for the underlying revocation reason.

i. Revocations with Retroactive Effective Dates

A revocation based upon any one or more of the following reasons carries a retroactive effective date:

- (1) Federal exclusion or debarment;*
- (2) Felony conviction as described in 42 CFR §1001.2;*
- (3) License suspension or revocation; or*
- (4) Determination that the provider or supplier is no longer operational*

A revocation based upon any one or more of the reasons above is effective with the date of the exclusion, debarment, felony conviction, license suspension or revocation, or the date that CMS or the contractor determined that the provider or supplier is no longer operational.

For example, when a revocation is based on the revocation/suspension of a license, the effective date of the revocation and the date listed on the revocation letter shall be the date of the actual revocation/suspension of the license.

ii. Revocations with Prospective Effective Dates

The contractor shall use a prospective effective date (i.e., the date that is 30 days after CMS or the CMS contractor mails notice of its determination to the provider or supplier), for revocations that are based upon a reason or reasons not included in the above list of revocations with retroactive effective dates. For example, for revocations based upon 42 CFR 424.535(a)(8) abuse of billing, the effective date shall be 30 days after the notice of revocation is issued.

iii. Revocations Based Upon More than One Reason

When a revocation is based upon more than one reason, the contractor shall determine whether any of the reasons are included in the list of revocations with retroactive effective dates; and, if so, the contractor shall apply the appropriate retroactive date.

b. Revocation Reasons

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

The provider or supplier is determined not to be in compliance with the enrollment requirements in subpart P (of Part 424) or in the enrollment application applicable to its provider or supplier type, and has not submitted a plan of corrective action as outlined in 42 CFR Part 488. The provider or supplier may also be determined not to be in compliance if it has failed to pay any user fees as assessed under part 488 of this chapter.

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

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

- The provider or supplier does not have a physical business address or mobile unit where services can be rendered.
- The provider or supplier does not have a place where patient records are stored to determine the amounts due such provider or other person.
- The provider or supplier is not appropriately licensed.
- The provider or supplier is not authorized by the federal/state/local government to perform the services that it intends to render.
- The provider or supplier does not meet CMS regulatory requirements for the specialty that it is enrolled as.
- The provider or supplier does not have a valid social security number (SSN) or employer identification number (EIN) for itself, an owner, partner, managing organization/employee, officer, director, medical director, and/or authorized or delegated official.
- The provider or supplier fails to furnish complete and accurate information and all supporting documentation within 60 calendar days of the provider or supplier's notification from CMS or its contractor to submit an enrollment application and supporting documentation, or resubmit and certify to the accuracy of its enrollment information. (This revocation reason will not be used

in these cases if CMS has explicitly instructed the contractor to use deactivation reason §424.540(a)(3) in lieu thereof.)

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

With respect to the last bullet above – and, as applicable bullets 3, 4 and 5 – the contractor’s revocation letter shall cite the appropriate statutory and/or regulatory citation(s) containing the specific licensure/certification/authorization requirement(s) for that provider or supplier type. For a listing of some of these statutes and regulations, refer to section 10.4(M)(2) et seq. of this chapter.

Certified Providers

Certified providers and suppliers can be involuntarily terminated by the Centers for Medicare & Medicaid Services (CMS) Regional Offices (ROs) if the provider or supplier no longer meets CMS requirements, conditions of participation, or conditions of coverage. When this occurs, the CMS RO terminates the provider’s or supplier’s Provider Agreement and issues a Tie-Out Notice (Form CMS-2007) to the contractor that informs them that the Agreement is terminated.

Upon receipt of a Tie-Out notice from the RO, communicating an involuntary termination, contractors shall follow revocation procedures in the chapter and revoke the certified provider’s or supplier’s Medicare billing privileges under 42 CFR §424.535(a)(1). The contractor shall not process the involuntary termination of a certified provider as a deactivation based upon a voluntary withdrawal from Medicare.

The issuance of the Tie-Out for non-compliance of CMS enrollment requirements, conditions of participation, or conditions of coverage provides sufficient basis for the contractor to proceed with a revocation. The contractor is not required to contact the RO to obtain further details of the termination.

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

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

- (i) Excluded from the Medicare, Medicaid, and any other federal health care program, as defined in 42 CFR §1001.2, in accordance with section 1128, 1128A, 1156, 1842, 1862, 1867 or 1892 of the Act.
- (ii) Is debarred, suspended, or otherwise excluded from participating in any other federal procurement or nonprocurement program or activity in accordance with the FASA implementing regulations and the Department of Health and Human Services nonprocurement common rule at 45 CFR part 76.

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

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

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

- (i) Felony crimes against persons, such as murder, rape, assault, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions.
- (ii) Financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions.
- (iii) Any felony that placed the Medicare program or its beneficiaries at immediate risk, such as a malpractice suit that results in a conviction of criminal neglect or misconduct.
- (iv) Any felonies that would result in mandatory exclusion under section 1128(a) of the Act.
- (v) Revocations based on felony convictions are for a period to be determined by the Secretary, but not less than 10 years from the date of conviction if the individual has been convicted on one previous occasion for one or more offenses.

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

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

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

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

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

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

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

- An institutional provider does not submit an application fee or hardship exception request that meets the requirements set forth in §424.514 with the Medicare revalidation application; or
- (ii) The hardship exception is not granted and the institutional provider does not submit the applicable application form or application fee within 30 days of being notified that the hardship exception request was denied.
- (iii) (A) Either of the following occurs:
 - CMS is not able to deposit the full application amount into a government-owned account; or
 - The funds are not able to be credited to the United States Treasury;
- (iv) The provider or supplier lacks sufficient funds in the account at the banking institution whose name is imprinted on the check or other banking instrument to pay the application fee; or
- (v) There is any other reason why CMS or its Medicare contractor is unable to deposit the application fee into a government-owned account.

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

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

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

Abuse of billing privileges includes either of the following:

- (i) The provider or supplier submits a claim or claims for services that could not have been furnished to a specific individual on

the date of service. These instances include but are not limited to the following situations:

- Where the beneficiary is deceased.
- The directing physician or beneficiary is not in the state or country when services were furnished.
- When the equipment necessary for testing is not present where the testing is said to have occurred.

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

- The percentage of submitted claims that were denied.
- The reason(s) for the claim denials.
- Whether the provider or supplier has any history of final adverse actions (as that term is defined in §424.502) and the nature of any such actions.
- The length of time over which the pattern has continued.
- How long the provider or supplier has been enrolled in Medicare.
- Any other information regarding the provider or supplier's specific circumstances that CMS deems relevant to its determination as to whether the provider or supplier has or has not engaged in the pattern or practice described in this paragraph.

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

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

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

With respect to Revocation Reason 9:

- If the provider or supplier reports a change in practice location more than 30 days after the effective date of the change, the contractor shall not pursue a revocation on this basis. However, if the

contractor independently determines – through an on-site inspection under 42 CFR §424.535(a)(5)(ii) or via another verification process – that the individual’s or organization’s address has changed and the supplier has not notified the contractor of this within the aforementioned 30-day timeframe, the contractor may pursue a revocation (e.g., seeking PEOG’s approval to revoke).

- If an IDTF reports a change in ownership, change of location, change in general supervision or change in adverse legal actions more than 30 days after the effective date of the change, the contractor may pursue a revocation on this basis (e.g., seeking PEOG’s approval to revoke).
- If a supplier of Durable Medical Equipment, Prosthetics, Orthotics and Suppliers (DMEPOS) reports any changes of information more than 30 days after the effective date of the changes, the contractor may pursue a revocation on this basis (e.g., seeking PEOG’s approval to revoke).

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

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

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

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

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

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

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

CMS considers the following factors listed in 42 CFR §424.535(a)(12): (A) The reason(s) for the termination or revocation; (B) Whether the provider or supplier is currently terminated, revoked or otherwise barred from more than one program (for example, more than one State’s Medicaid program) or has been subject to any other sanctions during its participation in other programs, and; (C) Any other information that CMS deems relevant to its determination.

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

- (i) The physician or eligible professional's Drug Enforcement Administration (DEA) Certificate of Registration is suspended or revoked; or
- (ii) The applicable licensing or administrative body for any state in which the physician or eligible professional practices suspends or revokes the physician or eligible professional's ability to prescribe drugs.

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

CMS determines that the physician or eligible professional has a pattern or practice of prescribing Part D drugs that falls into one of the following categories:

- (i) The pattern or practice is abusive or represents a threat to the health and safety of Medicare beneficiaries or both.
- (ii) The pattern or practice of prescribing fails to meet Medicare requirements.

CMS considers the following factors listed in 42 CFR §424.535(a)(14): (A) Whether there are diagnoses to support the indications for which the drugs were prescribed; (B) Whether there are instances when the necessary evaluation of the patient for whom the drug was prescribed could not have occurred (for example, the patient was deceased or out of state at the time of the alleged office visit); (C) Whether the physician or eligible professional has prescribed controlled substances in excessive dosages that are linked to patient overdoses; (D) The number and type(s) of disciplinary actions taken against the physician or eligible professional by the licensing body or medical board for the State or States in which he or she practices, and the reason(s) for the action(s); (E) Whether the physician or eligible professional has any history of “final adverse actions” (as that term is defined in §424.502); (F) The number and type(s) of malpractice suits that have been filed against the physician or eligible professional related to prescribing that have resulted in a final judgment against the physician or eligible professional or in which the physician or eligible professional has paid a settlement to the plaintiff(s) (to the extent this can be determined); (G) Whether any State Medicaid program or any other public or private health insurance program has restricted, suspended, revoked, or terminated the physician or eligible professional's ability to prescribe medications, and the reason(s) for any such restriction, suspension, revocation, or termination, and; (H) Any other relevant information provided to CMS.

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

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

The provider or supplier has an existing debt that CMS appropriately refers to the United States Department of Treasury.

CMS considers the following factors listed in 42 CFR §424.535(a)(17): (i) The reason(s) for the failure to fully repay the debt (to the extent this can be determined); (ii) Whether the provider or supplier has attempted to repay the debt (to the extent this can be determined); (iii) Whether the provider or supplier has responded to CMS' requests for payment (to the extent this can be determined); (iv) Whether the provider or supplier has any history of final adverse actions or Medicare or Medicaid payment suspensions; (v) The amount of the debt, and; (vi) Any other evidence that CMS deems relevant to its determination.

NOTE: With respect to (a)(17), PEOG – rather than the contractor – will make all determinations regarding whether a provider or supplier has an existing debt that has been referred to the Department of Treasury.

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

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

- Owning and managing organizations and individuals (regardless if the organizations or individuals are disclosed on the CMS-855 or CMS-20134 application);
- Geographic location;
- Provider or supplier type;
- Business structure; or
- Any evidence that the two parties (the revoked provider or supplier and newly-enrolling provider or supplier) are similar or that the provider or supplier was created to circumvent the revocation or re-enrollment bar.

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

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

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

- (1) The duration of the affiliation.

- (2) Whether the affiliation still exists and, if not, how long ago it ended.
- (3) The degree and extent of the affiliation.
- (4) If applicable, the reason for the termination of the affiliation.
- (5) Regarding the affiliated provider's or supplier's disclosable event under paragraph (b) of this section:
 - (i) The type of disclosable event.
 - (ii) When the disclosable event occurred or was imposed.
 - (iii) Whether the affiliation existed when the disclosable event occurred or was imposed.
 - (iv) If the disclosable event is an uncollected debt:
 - (A) The amount of the debt.
 - (B) Whether the affiliated provider or supplier is repaying the debt.
 - (C) To whom the debt is owed.
 - (v) If a denial, revocation, termination, exclusion, or payment suspension is involved, the reason for the disclosable event.

An affiliation is defined as:

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

NOTE: With respect to (a)(19), PEOG -- rather than the contractor -- will make all determinations regarding whether a provider or supplier has an affiliation per 42 CFR §424.519 that poses an undue risk of fraud, waste and abuse.

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

The provider or supplier billed for services performed at or items furnished from a location that it knew or should have known did not comply with Medicare enrollment requirements. The provider or supplier's Medicare enrollment or enrollments may be revoked even if all of the practice locations associated with a particular enrollment comply with Medicare enrollment requirements. In making its determination, CMS considers the following factors:

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

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

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

The physician or eligible professional has a pattern or practice of ordering, certifying, referring or prescribing Medicare Part A or B services, items or drugs that is abusive, represents a threat to the health and safety of Medicare beneficiaries or otherwise fails to meet Medicare requirements. In making its determination, CMS considers the following factors:

- Whether the physician or eligible professional's diagnosis supports the order, certification, referral or prescription in question;
- Whether there are instances where the necessary evaluation of the patient for whom the order, certification, referral or prescription could have not occurred (for example: the patient was deceased or out of state at the time of the alleged office visit);
- The number and types of disciplinary actions taken against the physician or eligible professional by the licensing body or medical board for the state(s) in which he or she practices and the reason(s) for the action(s);
- Whether the physician or eligible professional has any history of final adverse actions (as defined by 42 CFR §424.502);
- The length of time over which the pattern or practice has continued;

- How long the physician or eligible professional has been enrolled in Medicare;
- The number of type(s) of malpractice suits that have been filed against the physician or eligible professional related to ordering, certifying, referring or prescribing that resulted in a final judgement against the physician or eligible professional or the physician or eligible professional paid a settlement to the plaintiff(s) (to the extent this can be determined);
- Whether any State Medicaid Agency (SMA) or other public health insurance program has restricted, suspended, revoked or terminated the physician's or eligible professional's ability to practice medicine and reason for any such restriction, suspension, revocation or termination; and
- Any other information that CMS deems relevant to its determination.

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

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

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

- The nature of the patient harm.
- The nature of the physician's or other eligible professional's conduct.
- The number and type(s) of sanctions or disciplinary actions that have been imposed against the physician or other eligible professional by the State oversight board, IRO, Federal or State health care program, or any other equivalent governmental body or program that oversees, regulates, or administers the provision of health care. Such actions include, but are not limited to in scope or degree:
 - License restriction(s) pertaining to certain procedures or practices.
 - Required compliance appearances before State medical board members.
 - License restriction(s) regarding the ability to treat certain types of patients (for example, cannot be alone with members of a different gender after a sexual offense charge).
 - Administrative or monetary penalties.
 - Formal reprimand(s).
 - If applicable, the nature of the IRO determination(s).

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

This section does not apply to actions or orders pertaining exclusively to either of the following:

- Required participation in rehabilitation or mental/behavioral health programs; or
- Required abstinence from drugs or alcohol and random drug testing.

c. Extension of Revocation

If a provider's or supplier's Medicare enrollment is revoked under section 10.4(M) of this chapter, CMS may revoke any and all of the provider's or supplier's Medicare enrollments, including those under different names, numerical identifiers or business identities and those under different types.

In determining whether to revoke a provider's or supplier's other enrollments, CMS considers the following factors:

- The reason for the revocation and the facts of the case,
- Whether any final adverse actions have been imposed against the provider or supplier regarding its other enrollments,
- The number and type(s) of other enrollments, and

Any other information that CMS deems relevant to its determination.

d. Re-enrollment Bar

i. Background

As stated in 42 CFR §424.535(c), if a provider, supplier, owner, or managing employee has their billing privileges revoked, they are barred from participating in the Medicare program from the effective date of the revocation until the end of the re-enrollment bar. The re-enrollment bar begins 30 days after CMS or its contractor mails notice of the revocation and lasts a minimum of 1 year, but not greater than 10 years, depending on the severity of the basis for revocation. In addition, CMS may impose a re-enrollment bar of up to 20 years if the provider or supplier is being revoked from Medicare for the second time.

Per §424.535(c), the re-enrollment bar does not apply if the revocation: (1) is based on §424.535(a)(1), and (2) stems from a provider or supplier's failure to respond timely to a revalidation request or other request for information. If both of these conditions are met, no re-enrollment bar will be applied.

The contractor shall update the Provider Enrollment, Chain and Ownership System (PECOS) to reflect that the individual is prohibited from participating in Medicare for the applicable 1 through 10 as well

as a 20-year period. Re-enrollment bars that exceed 3 years will be determined by PEOG, rather than the contractor.

In addition, CMS may add up to 3 more years to the provider's or supplier's reenrollment bar if it determines that the provider or supplier is attempting to circumvent its existing reenrollment bar.

ii. Establishment of Length

The following serves merely as general, non-binding guidance regarding the establishment of the length of reenrollment bars. It is crucial to note that every situation must and will be judged on its own merits, facts, and circumstances, and it should not be assumed that a particular timeframe will always be applied to a specific revocation reason in all cases. CMS retains the discretion to apply a reenrollment bar period that is different from that indicated below (though which in no case will be greater than 10 to 20 years).

- §424.535(a)(1) (Noncompliance) -- For licensure issues, 1 year if no billing after loss of license
- §424.535(a)(6) (Grounds Related to Screening) – 1 year
- §424.535(a)(11) (Initial Reserve Operating Funds) – 1 year

Revocation reasons §424.535(a)(17) (Debt Referred to the United States Department of Treasury), §424.535(a)(18) (Revoked Under a Different Name, Numerical Identifier or Business Identity), §424.535(a)(19) (Affiliation that Poses an Undue Risk), §424.535(a)(20) (Billing from a Non-Compliant Location, §424.535(a)(21) (Abusive Ordering, Certifying, Referring, or Prescribing of Part A or B Services, Items or Drugs) and §424.535(a)(22) (Patient Harm) will receive re-enrollment bar lengths per CMS' discretion.

iii Applicability of Bar

In general, and unless stated otherwise above, any re-enrollment bar at a minimum applies to (1) all practice locations under the provider's PECOS or legacy enrollment record, (2) any effort to re-establish any of these locations (i) at a different address, and/or (ii) under a different business or legal identity, structure, or TIN. If the contractor receives an application and is unsure as to whether a revoked provider is attempting to re-establish a revoked location, it shall contact its PEOG BFL for guidance. Instances where the provider might be attempting to do so include - but are not limited to – the following:

- John Smith was the sole owner of Group Practice X, a sole proprietorship. Six months after X was revoked under §424.535(a)(9), the contractor receives an initial application from Group Practice Medicine, LLC, of which John Smith is the sole owner/member.
- Jack Jones and Stan Smith were 50 percent owners of World Home Health Agency, a partnership. One year after World Home Health

was revoked under §424.535(a)(7), the contractor receives an initial application from XYZ Home Health, a corporation owned by Jack Jones and his wife, Jane Jones.

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

e. Representing Provider Enrollment Appeals Process in a Revocation Letter

In the revocation letter, the contractor shall include information concerning a provider/supplier's appeal rights. The following table summarizes where a Corrective Action Plan (CAP) and/or Reconsideration Request must be sent.

| | CAP requests should be sent to: | | Reconsideration request should be sent to: | |
|--|--|--------------------------|---|--------------------------|
| Revocation Regulation | Institutional* | Non-institutional | Institutional* | Non-institutional |
| 424.535(a)(1) related to an enrollment requirement (i.e., 425.516) | Alone or in combination: CMS | MAC | CMS | MAC |
| 424.535(a)(1) Licensure | CAP rights (to CMS) | CAP rights (to the MAC) | CMS | MAC |
| 424.535(a)(1) DME or IDTF | CAP rights (to CMS) | CAP rights (to the MAC) | CMS | MAC |
| 424.535(a)(2) Exclusion | No CAP rights | No CAP rights | CMS | CMS |
| 424.535(a)(2) Debarment | No CAP rights | No CAP rights | CMS | CMS |
| 424.535(a)(3) | No CAP rights | No CAP rights | CMS | CMS |
| 424.535(a)(4) | No CAP rights | No CAP rights | CMS | CMS |
| 424.535(a)(5) | No CAP rights | No CAP rights | CMS | MAC |
| 424.535(a)(6) | No CAP rights | No CAP rights | CMS | MAC |
| 424.535(a)(7) | No CAP rights | No CAP rights | CMS | CMS |
| 424.535(a)(8) | No CAP rights | No CAP rights | CMS | CMS |
| 424.535(a)(8) | No CAP rights | No CAP rights | CMS | CMS |
| 424.535(a)(9) | No CAP rights | No CAP rights | CMS | MAC |
| 424.535(a)(10) | No CAP rights | No CAP rights | CMS | CMS |
| 424.535(a)(11) | No CAP rights | No CAP rights | CMS | CMS |
| 424.535(a)(12) | No CAP rights | No CAP rights | CMS | CMS |
| 424.535(a)(13) | No CAP rights | No CAP rights | CMS | CMS |
| 424.535(a)(14) | No CAP rights | No CAP rights | CMS | CMS |
| 424.535(a)(17) | No CAP rights | No CAP rights | CMS | CMS |
| 424.535(a)(18) | No CAP rights | No CAP rights | CMS | CMS |
| 424.535(a)(19) | No CAP rights | No CAP rights | CMS | CMS |
| 424.535(a)(20) | No CAP rights | No CAP rights | CMS | CMS |

| | | | | |
|----------------|---------------|---------------|-----|-----|
| 424.535(a)(21) | No CAP rights | No CAP rights | CMS | CMS |
| 424.535(a)(22) | No CAP rights | No CAP rights | CMS | CMS |

*Institutional providers:

- Ambulance Service Suppliers
- Ambulatory Surgery Centers
- CLIA Labs
- Community Mental Health Center
- Comprehensive Outpatient Rehabilitation Facilities (CORFs)
- Critical Access Hospitals
- End Stage Renal Disease (ESRDs)
- Federally Qualified Health Careers (FQHCs)
- Histocompatibility Laboratories
- Home Health Agencies
- Hospices
- Hospitals and Hospital Units
- Independent Diagnostic Testing Facilities (IDTFs)
- Indian Health Service Facility
- Intensive Cardiac Rehabilitation
- Mammography Screening Centers
- Mass Immunization/Flu Roster Billers
- Medicare Diabetes Prevention Program (MDPP) Suppliers
- Opioid Treatment Centers (OTPs)
- Organ Procurement Organizations (OPOs)
- Outpatient Physical Therapy/Outpatient Speech Pathology Services (OPT/OSP)
- Pharmacies
- Portable X-Ray Suppliers (PXRSs)
- Radiation Therapy Centers
- Rehabilitation Services
- Religious Non-Medical Health Care Institutions (RNCHIs)
- Rural Health Clinics (RHCs)
- Skilled Nursing Facilities (SNFs)

CMS has defined "institutional provider" to mean any provider or supplier that submits a paper Medicare enrollment application using the CMS-855A, CMS-855B (except physician and non-physician practitioner organizations), or CMS-855S or the associated Internet-based PECOS enrollment application.

For more information regarding the provider enrollment appeals process, see Section *10.6.18 of this chapter*.

3. Revocations: Other Policies

a. Revocation and Claims: submission of Claims for Services Furnished Before Revocation

Per 42 CFR §424.535(h), a revoked provider or supplier (other than a home health agency (HHA)) must, within 60 calendar days after the effective date of revocation, submit all claims for items and services furnished before the date of the revocation letter. A revoked HHA must submit all claims for items and services within 60 days after the

later of: (1) the effective date of the revocation, or (2) the date that the HHA's last payable episode ends.

Nothing in 42 CFR §424.535(h) impacts the requirements of § 424.44 regarding the timely filing of claims.

b. Revocations Based Upon Not Meeting Reporting Requirements

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

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

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

To accomplish this task, CMS will provide a monthly revoked and denied provider list to all contractors via the Share Point Ensemble site. The contractor shall access this list on the 5th day of each month through the Share Point Ensemble site. The contractor shall review the monthly revoked and denied provider list for the names of Medicare providers revoked and denied in PECOS. The contractor shall document any appeals actions a provider/supplier may have submitted subsequent to the provider or supplier's revocation or denial.

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

Appeal Submitted:

Yes - (definition: an appeal has been received. This includes either a CAP or Reconsideration request or notification of an ALJ or DAB action.)

No - (definition: no appeal of any type has been submitted)

Appeal Type:

CAP

Reconsideration

ALJ

DAB

Appeal Status:

Under Review

Revocation Upheld
Revocation Overturned
Denial Upheld
Denial Overturned
CAP accepted
CAP denied
Reconsideration Accepted
Reconsideration Denied

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

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

Contractors shall submit their completed reports by the 20th of each month to the CGI Share Point Ensemble site.

**d. Revocations of Certified Providers and Certified Suppliers:
Special Instructions**

Section 10.4.1(M)(3)(d) describes the contractor's required action to revoke the enrollment of a certified provider/supplier that is involuntarily terminated by the RO.

The contractor need not obtain prior approval from the state/RO prior to revoking a certified provider or certified supplier's billing privileges. When revoking the provider/supplier, however, the contractor shall:

- E-mail a copy of the revocation letter to the applicable RO's Division of Survey & Certification corporate mailbox. (The RO will notify the state of the revocation.)
- After determining the effective date of the revocation, end-date the entity's enrollment record in the Provider Enrollment, Chain and Ownership System (PECOS) in the same manner as it would upon receipt of a tie-out notice from the RO.
- Afford the appropriate appeal rights per Section *10.6.18 of this chapter*.

e. Opting-Out After Revocation

Providers who are revoked from Medicare will not be able to order, certify or prescribe Part A or B Services, items, or drugs to Medicare beneficiaries if they opt-out of Medicare after revocation.

For example, if Dr. Thompson is revoked from Medicare, he will not be able to opt-out and order back and knee orthoses for his patients.

f. Overpayments Based Upon Revocations

The contractor shall initiate procedures to collect overpayment after the timeframe for the appeal of the revocation has expired or within 10 days of the final appeal determination at the first level of appeal.

Overpayments are processed in accordance with 42 CFR 405 Subpart C.

In situations where a revocation is made with a prospective (i.e., 30 days from the date of CMS or the contractor's mailing of the revocation notification letter to the provider) effective date, the contractor's shall assess an overpayment back to a date that is the more recent of the following:

- The date when Medicare claims are determined to be ineligible for payment; or,
- The date that is within 4 years from the date of the initial claim determination or redetermination for good cause as defined in 42 CFR §405.986 (42 CFR §405.980).

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

In accordance with 42 CFR §424.565, if a physician, non-physician practitioner, physician organization or non-physician practitioner organization fails to comply with the reporting requirements specified in 42 CFR §424.516(d)(1)(ii), the contractor may assess an overpayment back to a date that is the more recent of the following:

- The date of the final adverse action or change in practice location; or,
- The date that is within 4 years from the date of the initial claim determination or redetermination for good cause as defined in 42 CFR §405.986 (42 CFR §405.980).

4. Sources of Identified Revocations

When CMS directs the contractor to take a revocation action, such direction is communicated to the contractor directly from CMS PEOG. This section describes how a subset of potential revocation actions are identified. Regarding these potential revocations, a contractor takes action to revoke a provider based upon approval or technical direction from PEOG (i.e., Zone Program Integrity Contractor or RO personnel may not direct a contractor to revoke a provider).

a. Unified Program Integrity Contractor (UPIC) Identified Revocations

If, through its investigations, the UPIC believes that a particular provider's or supplier's Medicare billing privileges should be revoked, it shall develop a case file - including the reason(s) for revocation - and submit the file and all supporting documentation to the Provider Enrollment & Oversight Group (PEOG). The UPIC shall provide PEOG with the information described in (2) below.

PEOG will review the case file and:

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

If PEOG approves the revocation recommendation, PEOG will: (1) ensure that the applicable contractor is instructed to revoke the provider's/supplier's Medicare enrollment, and (2) notify the applicable contracting officer's representative (COR) in the Division of Medicare Integrity Contractor Operations of the action taken.

If the contractor receives a direct request from a UPIC to revoke a provider's or supplier's Medicare enrollment, it shall refer the matter to its Provider Enrollment Oversight Group (PEOG) Business Function Lead (BFL) if it is unsure whether the UPIC received prior PEOG approval for the revocation.

b. CMS Field Office or Regional Office Identified Revocations

If a CMS field office (SO) or regional office (RO) believes that the use of Revocation Reason 8 (see 42 CFR §424.535(a)(8) is appropriate), the FO/RO will develop a case file - including the reason(s) for revocation - and submit the file and all supporting documentation to PEOG. The case file must include the name, all known identification numbers - including the National Provider Identifier and associated Provider Transaction Access Numbers - and locations of the provider or supplier, as well as detailed information to substantiate the revocation action.

If PEOG concurs with the FO/RO's revocation recommendation, PEOG will: (1) instruct the contractor to revoke the provider/supplier's Medicare billing privileges, and (2) notify the FO/RO of same.

In regards to involuntary termination of certified provider/supplier, Section 10.4(M)(3)(d) of this chapter describes the contractor's required action to revoke the enrollment of a certified provider/supplier that is involuntarily terminated by the RO.

c. U.S. Department of Health & Human Services Office of Inspector General (HHS OIG) Identified Revocations

Actions based on HHS OIG Identified Revocations are the responsibility of PEOG.

d. MDPP Supplier Revocation for Use of an ineligible coach

i. General Procedures

42 CFR §424.205(h)(v) established a new revocation reason specifically for MDPP suppliers for a specific circumstance in which the MDPP supplier knowingly permitted an ineligible coach to furnish MDPP services to beneficiaries, despite being previously removed from the MDPP supplier's roster through a CAP.

If a contractor or UPIC suspects this scenario, it shall develop a case file - including the reason(s) - and submit the file and all supporting documentation to the Provider Enrollment & Oversight Group

(PEOG). The contractor shall provide PEOG with the information described in (2) below.

PEOG will review the case file and:

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

If PEOG approves the revocation recommendation, PEOG will: (1) ensure that the applicable Medicare Administrative Contractor (contractor) is instructed to revoke the provider's/supplier's Medicare enrollment, and (2) notify the applicable contracting officer's representative (COR) in the Division of Medicare Integrity Contractor Operations of the action taken.

If the contractor receives a direct request from a UPIC to revoke a provider's or supplier's Medicare enrollment, it shall refer the matter to its PEOG Business Function Lead (PEOG BFL) if it is unsure whether the UPIC received prior PEOG approval for the revocation.

ii. Revocation Request Data

The revocation request shall contain the following information:

- Provider/supplier name; administrative location(s); community setting(s) if applicable type (e.g., DMEPOS supplier); Provider Transaction Access Number; National Provider Identifier; applicable Medicare Administrative Contractor
- Name(s), e-mail address(es), and phone number(s) of investigators
- Tracking number
- Provider/supplier's billing status (Active? Inactive? For how long?)
- Whether the provider/supplier is a Fraud Prevention System provider/supplier
- Source/Special Project
- Whether the provider/supplier is under a current payment suspension
- Legal basis for revocation
- Relevant facts
- Application of facts to revocation reason
- Any other notable facts

- Effective date (per 42 CFR § 424.535(g))
- Supporting documentation
- Photos (which should be copied and pasted within the document)

iii. Effective Dates

If revoked under this authority, the MDPP supplier does not have CAP rights. The revocation becomes effective 30 days after the contractor sends notice of the revocation.

iv. Reenrollment Bar

As stated in 42 CFR §424.205(h), if an MDPP supplier, owner, or managing employee has their billing privileges revoked, they are barred from participating in the Medicare program from the effective date of the revocation until the end of the re-enrollment bar. The re-enrollment bar begins 30 days after CMS or its contractor mails notice of the revocation and lasts a minimum of 1 year, but not greater than 3 years, depending on the severity of the basis for revocation.

v. Processing information

Refer to 10.4(M)(1)(a) and 10.4(M)(3)(a)(i) for additional processing information that also apply to this revocation reason.

N. Deactivations

1. Reasons

Unless indicated otherwise in this chapter or in another CMS instruction or directive, the contractor shall – without prior approval from its CMS Provider Enrollment Business Function Lead (PEBFL) - deactivate a provider or supplier's entire enrollment record and Medicare billing privileges when:

- A provider or supplier fails to respond to a revalidation request;
- A provider or supplier fails to respond timely to a revalidation development request,
- A provider is enrolled in an approved status without an active reassignment or practice location for 90 days or longer, or
- A provider deactivates an EFT Agreement and remains enrolled but does not submit a new EFT agreement within 90 days.

The contractor shall not take deactivation actions unless specified in this chapter or other CMS directives.

2. Regulations

- Per §424.540(a)(1), a provider or supplier does not submit any Medicare claims for 12 consecutive calendar months. The 12-month

period begins on the 1st day of the 1st month without a claims submission through the last day of the 12th month without a submitted claim;

- Per §424.540(a)(2), a provider or supplier fails to report a change to the information supplied on the enrollment application within 90 calendar days of when the change occurred. Changes that must be reported include, but are not limited to, a change in practice location, a change of any managing employee, and a change in billing services; a provider or supplier fails to report a change in ownership or control within 30 calendar days.
- Per §424.540(a)(3), a provider or supplier does not furnish complete and accurate information and all supporting documentation within 90 calendar days of receipt of notification from CMS to submit an enrollment application and supporting documentation, or resubmit and certify to the accuracy of its enrollment information.

3. Effective Dates

The effective dates of a deactivation are as follows:

- a. Non-Billing §424.540(a)(1) – The effective date is the date the action is taken unless stated otherwise in this chapter or another CMS directive.
- b. Failure to Report or Furnish Information §424.540(a)(2) and (3), – The effective date is the date the action is taken unless stated otherwise in this chapter or another CMS directive.
- c. The “36-Month Rule” for HHAs – CMS’ provider enrollment staff will determine the effective date during its review of the case.

4. Rebuttal Rights

A provider or supplier whose Medicare billing privileges have been deactivated may file a rebuttal to challenge the deactivation. See Section ***10.4(O) of this chapter*** for further instruction.

5. Miscellaneous

- a. The deactivation of Medicare billing privileges does not affect a supplier's participation agreement (CMS-460).
- b. Prior to deactivating an HHA's billing privileges for any reason (including under the “36-month rule”), the contractor shall refer the matter to its PEBFL for review and approval. The only exception for PEBFL review and approval is deactivations due to failure to comply with a revalidation request.

O. Rebuttal Process

1. Background

Pursuant to 42 C.F.R. § 424.545(b), a provider or supplier whose Medicare billing privileges have been deactivated may file a rebuttal in accordance with 42 C.F.R. § 405.374. A rebuttal is an opportunity for the provider or supplier to demonstrate that it meets all applicable enrollment requirements and that its Medicare billing privileges should not have been deactivated. Only one rebuttal request may be submitted per deactivation. Additional rebuttal requests shall be dismissed.

If an application is received for a deactivated provider or supplier while a rebuttal submission is pending or during the rebuttal submission timeframe, the contractor shall process the application in accordance with current processing instruction. If the rebuttal determination is issued and overturns the deactivation prior to an application being approved, the contractor shall return the application received while the rebuttal determination was pending unless the submitted application is required to reactivate the provider's or supplier's enrollment. If an application, received while a rebuttal submission is pending, is approved prior to the issuance of a rebuttal determination and results in the provider's or supplier's enrollment being reactivated without a gap in billing privileges, the contractor shall stop processing the rebuttal submission and issue an applicable moot letter.

Providers and suppliers may submit a rebuttal request for the following deactivation reasons, in accordance with 42 C.F.R. § 424.540(a):

- (1) The provider or supplier does not submit any Medicare claims for 12 consecutive calendar months. The 12-month period will begin the 1st day of the 1st month without a claims submission through the last day of the 12th month without a submitted claim.*
- (2) The provider or supplier does not report a change to the information supplied on the enrollment application within 90 calendar days of when the change occurred. Changes that must be reported include, but are not limited to, a change in practice location, a change of any managing employee, and a change in billing services. A change in ownership or control must be reported within 30 calendar days as specified in §§ 424.520(b) and 424.550(b).*
- (3) The provider or supplier does not furnish complete and accurate information and all supporting documentation within 90 calendar days of receipt of notification from CMS to submit an enrollment application and supporting documentation, or resubmit and certify to the accuracy of its enrollment information.*

2. Notification Letters for Deactivations

If a basis is found to deactivate a provider's or supplier's Medicare billing privileges under one of the regulatory authorities identified in 42 C.F.R. § 424.540, the contractor shall deactivate the provider's or supplier's Medicare billing privileges unless another CMS direction is applicable. If a revocation authority is applicable, the contractor shall follow the current revocation instruction in Section 10.4(M) of this chapter, in lieu of deactivating the enrollment. If no revocation authority is applicable, the contractor shall send notification of the deactivation using the applicable model deactivation notice. The contractor shall ensure the deactivation notice contains sufficient details so it is clear why the provider's or

supplier's Medicare billing privileges are being deactivated. The contractor shall send the deactivation notification letter via hard-copy mail and via email if a valid email address is available. The contractor should also send via fax if a valid fax number is available. All notifications shall be saved in PDF format. All notification letters shall be mailed on the same date listed on the letter.

P. Rebuttal Submissions

1. Requirements and Submission of Rebuttals

The rebuttal submission:

- a. Must be received by the contractor within 20 calendar days from the date of the deactivation notice. The contractor shall accept a rebuttal submission via hard-copy mail, email, and/or fax;*
- b. Must specify the facts or issues with which the provider or supplier disagrees, and the reasons for disagreement;*
- c. Should include all documentation and information the provider or supplier would like to be considered in reviewing the deactivation;*
- d. Must be submitted in the form of a letter that is signed and dated by the individual provider, supplier, the authorized or delegated official, or a legal representative, as defined in 42 C.F.R. § 498.10. If the legal representative is an attorney, the attorney must include a statement that he or she has the authority to represent the provider or supplier. This statement is sufficient to constitute notice. If the legal representative is not an attorney, the provider or supplier must file written notice of the appointment of a representative with the contractor. This notice of appointment must be signed and dated by the individual provider or supplier, the authorized or delegated official, or a legal representative.*

If the rebuttal submission is not appropriately signed or if a statement from the attorney or written notice of representation is not included in the submission, the contractor shall send a develop request for a proper signature or the missing statement/written notice (using the applicable model letter) before dismissing the rebuttal submission. The contractor shall allow 15 calendar days from the date of the development request letter for the rebuttal submitter to respond to the development request.

If a rebuttal submission is not appropriately signed and no response is received to the development request (if applicable), untimely (as described above), does not specify the facts or issues with which the provider or supplier disagrees and the reasons for disagreement, or is a duplicative submission, the contractor shall dismiss the rebuttal submission using the applicable model rebuttal dismissal letter. The contractor may make a good cause determination so as to accept any rebuttal that has been submitted beyond the 20 calendar day filing timeframe. Good cause may be found where there are circumstances beyond the provider's or supplier's control that prevented the timely submission of a rebuttal. These uncontrollable circumstances do not include the provider's or supplier's failure to timely update its enrollment information, specifically its various addresses. If the contractor believes good cause exists to accept an untimely rebuttal

submission, the contractor shall send a request approval email to ProviderEnrollmentAppeals@cms.hhs.gov within five calendar days of making the good cause determination. This email shall detail the contractor's reasoning for finding good cause. Processing timeliness standards shall begin on the date the contractor receives a response from CMS.

2. Time Calculations for Rebuttal Submissions

The date of receipt of a deactivation notice is presumed to be 5 days after the date on the deactivation notice unless there is a showing that it was, in fact, received earlier or later.

Therefore, the rebuttal must be received within 20 calendar days from the date of the deactivation notice to be considered timely. If the 20th calendar day from the date on the deactivation notice falls on a weekend or federally recognized holiday, then the rebuttal shall be accepted as timely if received by the next business day.

Consider the following example:

A deactivation notice is dated April 8, 2018. The provider or supplier is presumed to have received the deactivation notice on April 13, 2018. The provider or supplier submits a rebuttal that is received on April 28, 2018. The 20th calendar day from the date on the deactivation notice is April 28, 2018. However, since April 28, 2018 is a Saturday (weekend day), the rebuttal submission received on April 30, 2018 is considered timely because April 30, 2018 is the next business day following the 20th calendar day from the date on the deactivation notice.

It is the provider's or supplier's responsibility to timely update its enrollment record to reflect any changes to the provider's or supplier's enrollment information including, but not limited to its correspondence address. Failure to timely update a correspondence address or other addresses included in its Medicare enrollment record does not constitute an "in fact" showing that the deactivation notice was received after the presumed receipt date (as described above).

3. Processing Rebuttal Submissions

The contractor shall send an acknowledgement letter via hard-copy mail to the return address on the rebuttal submission within 10 calendar days of receipt of the accepted rebuttal request using the model rebuttal acknowledgement letter, including a rebuttal tracking number. The acknowledgement letter shall also be sent via email, if a valid email address is available. It is optional for the contractor to send the acknowledgement letter via fax, if a valid fax number is available.

The contractor shall process all accepted rebuttal submissions within 30 calendar days of the date of receipt. If while reviewing the rebuttal submission, the provider or supplier wishes to withdraw its rebuttal, the request to withdraw must be submitted to the contractor in writing before the rebuttal determination is issued.

The contractor's review shall only consist of whether the provider or supplier met the enrollment requirements and if billing privileges were deactivated appropriately. All materials received by the provider or supplier shall be considered by the contractor in their review.

a) For deactivations under 42 C. F. R. § 424.540(a)(1), the contractor shall review submitted documentation and internal systems to confirm whether billing occurred during the twelve-month period preceding the date of deactivation, starting with the 1st day of the 1st month twelve months prior to the date of deactivation. If it is confirmed that billing occurred within twelve months, the contractor shall issue a favorable rebuttal determination. If no billing occurred during the twelve-month period prior to the date of deactivation, the contractor shall issue an unfavorable rebuttal determination.

Consider the following example:

Dr. Awesome has been enrolled in the Medicare program since 2010. A review of billing data reveals that Dr. Awesome has not submitted any Medicare claims since January 2016. Dr. Awesome's enrollment is deactivated effective January 1, 2018. Dr. Awesome timely submits a rebuttal statement regarding the deactivation. Upon the contractor's review of the submitted documentation and internal records, it is confirmed that Dr. Awesome had not submitted claims since January 2016. Therefore, an unfavorable determination would be appropriate in this scenario, as the deactivation was justified.

- For deactivations under 42 C. F. R. § 424.540(a)(2), the contractor shall review the submitted documentation and internal records to determine whether the change of information was properly submitted within 90 calendar days of when the change occurred. If information was submitted properly and timely, the contractor shall approve the rebuttal request and reinstate the provider's or supplier's Medicare billing privileges to an approved status. If it was not submitted properly and timely, the contractor shall deny the rebuttal request, as the deactivation was justified. In making this determination, the contractor shall consider, at minimum, the following.*
 - Whether the deactivation was implemented after 90 days of when the change of enrollment information occurred.*
 - Whether the letter notifying the provider or supplier of the deactivation was sent to the correct address as instructed in section 10.7 of this chapter.*
 - Whether the enrollment changes were received in an enrollment application that was processed to completion within 90 days of when the change of enrollment occurred.*

Consider the following example:

Dr. Happy has reassigned his benefits to physician group Smile, LLC. Smile, LLC is Dr. Happy's only reassignment and only practice location. Smile, LLC's billing privileges are revoked effective January 1, 2018. Dr. Happy's enrollment is deactivated on April 15, 2018 for failing to update his enrollment record with respect to his practice location. Dr. Happy timely submits a rebuttal to the deactivation. Upon the contractor's review of the

submitted documentation and internal records, it is discovered that Dr. Happy submitted a change of information application received on February 28, 2018 that sought to update his practice location. However, this application was ultimately rejected due to his failure to timely respond to a development request.

In this scenario, the deactivation was correctly implemented after 90 days of the change of enrollment information – the change in practice location. However, an enrollment application updating Dr. Happy's practice location that was processed to completion was not received within 90 days of the change of enrollment information. Though an application was received within 90 days of the change of enrollment information, that application was not processed to completion. Therefore, an unfavorable rebuttal determination would be appropriate in this scenario, as the deactivation was justified.

- *For deactivations under 42 C. F. R. 424.540(a)(3), the contractor shall review all submitted documentation and internal records to determine whether the provider or supplier furnished complete and accurate information and all supporting documentation within 90 calendar days of receipt of notification from CMS to submit an enrollment application and supporting documentation, or resubmit and certify to the accuracy of its enrollment information. In making this determination, the contractor shall consider, at minimum, the following.*
 - *Whether the deactivation was implemented after 90 days of the revalidation request.*
 - *Whether the letter notifying the provider or supplier of the requirement to revalidate was sent to the correct address as instructed in section 10.7 of this chapter.*
 - *Whether a revalidation application was timely received that was processed to completion.*

Consider the following example:

On January 1, 2018, the contractor appropriately and timely informs Dr. Great that the contractor must receive a revalidation application from Dr. Great by April 15, 2018. The contractor receives a revalidation application from Dr. Great on March 1, 2018. The contractor requests that Dr. Great furnish further information needed to process the revalidation application. Dr. Great does not respond to the development request within 30 days as requested. The contractor rejects the March 1, 2018 revalidation application and subsequently deactivates Dr. Great's enrollment on April 16, 2018. Dr. Great timely files a rebuttal in response to the deactivation. Upon review of the submitted documentation and internal records, the contractor confirms that Dr. Great was appropriately and timely notified of the requirement to revalidate and that it did not receive a revalidation application within 90 days of the revalidation request that could be processed to completion. Therefore, an unfavorable rebuttal determination would be appropriate in this scenario, as the deactivation was justified.

The contractor shall render a determination regarding a rebuttal submission using the appropriate model rebuttal decision letter. If the contractor is unable to render a determination, the contractor shall use the appropriate model letter for the specific situation. All determinations (including dismissals and withdrawals) related to rebuttal submission shall

be sent via hard-copy mail to the return address on the rebuttal submission and by email, if a valid email address is available. The contractor may also send via fax if a valid fax number is available. All documentation shall be saved in PDF format. All notification letters shall be mailed on the same date listed on the letter.

If the contractor issues a rebuttal determination favorable to the provider or supplier, it shall make the necessary modification(s) to the provider or supplier's Medicare billing privileges within ten business days of the date the favorable determination is issued. This may include the elimination of the deactivation altogether so that there is no gap in billing privileges or a change in the deactivation effective date. If the contractor issues a rebuttal determination unfavorable to the provider or supplier, the provider's or supplier's Medicare billing privileges shall remain deactivated until a reactivation application is received and processed to completion.

If additional information/documentation is needed prior to reinstating the provider or supplier (e.g. deactivation due to non-response to revalidation and a complete application or missing information is needed to finalize the revalidation), the contractor shall document these next steps in their rebuttal determination letter. The contractor shall not reinstate the provider or supplier until the requested information is received and processed. If the additional information/documentation is not received within 30 calendar days of the date of the rebuttal determination, the contractor shall contact the provider or supplier to again request the additional information/documentation within 10 calendar days of not receiving a response. If no response is received within 30 calendar days of the second request for additional information/documentation, the contractor shall contact ProviderEnrollmentAppeals@cms.hhs.gov within 10 calendar days for further instruction.

4. Rebuttal Determination is Not Subject to Further Review

Pursuant to the rebuttal regulation at 42 C.F.R. § 405.375(c), a determination made regarding a rebuttal request is not an initial determination and is not subject to further review. Therefore, no additional appeal rights shall be included on any rebuttal determination letter.

10.6.18 – Appeals Process

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

A. Review Procedures for Determinations that Affect Participation in the Medicare Program

1. Background

This review process of initial determinations applies to all providers and suppliers and ensures that all current and prospective providers and suppliers receive a fair and full opportunity to be heard. With the implementation of the appeals provision of Section 936 of the Medicare Prescription Drug Modernization and Improvement Act (MMA), all providers and suppliers that wish to appeal will be given the opportunity to request Administrative Law Judge (ALJ) review of a reconsideration decision within the Civil Remedies Division of the Departmental Appeals Board (CRD DAB). Providers and suppliers may thereafter seek review of

the ALJ decision in the Appellate Division of the Departmental Appeals Board (DAB) and may then request judicial review in Federal District Court.

For purposes of this chapter, in accordance with 42 C.F.R. § 498.3, an initial determination includes: (1) the denial of enrollment in the Medicare program; (2) the revocation of a provider's or supplier's Medicare billing privileges; and (3) the effective date of participation in the Medicare program.

Any corrective action plan (CAP) or reconsideration request that purports to challenge an enrollment action other than the initial determinations identified above (including inclusion on the CMS Preclusion List and Opt-Out Status) shall be forwarded to CMS at ProviderEnrollmentAppeals@cms.hhs.gov for review within 10 business days of the date of receipt. The Medicare Administrative Contractor (MAC) shall take no action on the provider's or supplier's information on its enrollment record regarding an appeal submission for revocations forwarded to CMS for processing unless otherwise instructed by the Provider Enrollment and Oversight Group (PEOG).

A provider or supplier dissatisfied with the initial determinations referenced above, may challenge the determination. All properly submitted requests shall be reviewed at the enrollment level. As a result, if one letter attempts to challenge the initial determination for a group enrollment in addition to individual practitioner enrollment(s), each enrollment shall receive a separate decision. All submissions shall be processed in the order in which they are received. All CAPs and/or reconsideration requests will be reviewed by an individual separate and apart from the individual involved in the implementation of the initial determination.

Depending on the regulatory authority under which an initial determination is issued, providers and suppliers may be entitled to submit a CAP and/or a reconsideration request. A CAP is a plan that allows a provider or supplier an opportunity to demonstrate compliance with all applicable Medicare requirements by correcting the deficiencies (if possible) that led to the initial determination, specifically either the denial of enrollment into the Medicare program under 42 C.F.R. § 424.530(a)(1) or the revocation of Medicare billing privileges pursuant to 42 C.F.R. § 424.535(a)(1). While CAPs may only be submitted in response to a denial under 42 C.F.R. § 424.530(a)(1) or a revocation under 42 C.F.R. § 424.535(a)(1), all initial determinations allow for the submission of a reconsideration request. A reconsideration request allows the provider or supplier an opportunity to demonstrate that an error was made in the initial determination at the time the initial determination was implemented. In contrast to a CAP, a reconsideration request does not allow a provider or supplier the opportunity to correct the deficiencies that led to the initial determination.

Any CAPs and/or reconsideration requests received in response to initial determinations involving the following, either in whole or in part, shall be forwarded to CMS for review within 10 business days of the date of receipt. The CAP and/or reconsideration request shall be sent to the PEOG Provider Enrollment Appeals inbox at

ProviderEnrollmentAppeals@cms.hhs.gov.

- *All CAPs and reconsideration requests for certified providers/suppliers (as defined in Sections 10.2.1 and 10.2.2 of this chapter) and institutional providers/suppliers which have been revoked (as defined in Section 10.4(M)(2)(e) of this chapter);*
- *CAPs and reconsideration requests for Independent Diagnostic Testing Facilities;*
- *CAPs and reconsideration requests for Medicare Diabetes Prevention Programs (MDPP);*
- *CAPs and reconsideration requests for Opioid Therapy Programs (OTPs);*
- *Reconsideration requests for enrollment denials pursuant, in whole or in part, to 42 C.F.R. § 424.530(a)(2), (3), (6), (11), (12), (13), and (14);*
- *Reconsideration requests for revocations pursuant, in whole or in part, to 42 C.F.R. § 424.535(a)(2), (3), (4), (7), (8), (10), (12), (13), (14), (17), (18), (19), (20), (21) and (22);*
- *Requests for reversals of denials pursuant to 42 C.F.R. § 424.530(c) and/or revocations pursuant to 42 C.F.R. § 424.535(e);*
- *Reconsideration requests for revocations pursuant, in whole or in part, to 42 C.F.R. § 424.535(j);*
- *Reconsideration requests challenging the addition of years to an existing re-enrollment bar;*
- *Reconsideration requests challenging whether an individual or entity other than the provider or supplier that is the subject of the second revocation was the actual subject of the first revocation;*
- *Reconsideration requests challenging an individual or entity being included on the CMS Preclusion List as defined in § 422.2 or § 423.100; and*
- *Reconsideration requests regarding opt-out status.*

If the provider or supplier is denied enrollment or has its Medicare billing privileges revoked, under 42 C.F.R. § 424.530(a)(1) or 42 C.F.R. § 424.535(a)(1), (5) or (9), in conjunction with any denial or revocation reason(s) listed above, those CAPs and/or reconsideration requests should also be forwarded to CMS at ProviderEnrollmentAppeals@cms.hhs.gov for review within 10 business days of the date of receipt and the determination will be rendered by CMS. If the provider or supplier only submits a CAP for the noncompliance portion of any initial determinations listed above, the CAP must be sent to CMS at ProviderEnrollmentAppeals@cms.hhs.gov for review within 10 business days of the date of receipt, even if the provider or supplier does not submit a reconsideration request. The MAC shall not process the CAP if it is

required to be forwarded to CMS. If the provider or supplier later submits a reconsideration request, the reconsideration request must also be sent to CMS at ProviderEnrollmentAppeals@cms.hhs.gov within 10 business days of the date of receipt.

All CAPs and reconsideration requests received by the MACs that are not specifically identified above as being required to be forwarded to CMS for review, shall be processed and a decision rendered by the MACs.

However, CMS may exercise its discretion to review any CAP and/or reconsideration request and issue a decision regardless of the basis for the initial determination.

(NOTE: This includes all CAPs and reconsideration requests for DMEPOS suppliers that fit the criteria identified above. In addition, as also indicated above, CAPs may only be submitted for denials pursuant to 42 C.F.R. § 424.530(a)(1) and revocations pursuant to 42 C.F.R. § 424.535(a)(1). However, in the event a CAP is submitted for revocations pursuant, in whole or in part, to 42 C.F.R. § 424.535(a)(2), (3), (4), (7), (8), (10), (12), (13), (14), (17), (18), (19), (20), (21), or (22) the submission should still be forwarded to CMS within 10 business days of the date of receipt to the PEOG Provider Enrollment Appeals inbox at ProviderEnrollmentAppeals@cms.hhs.gov.)

PEOG shall notify the MAC via email when it receives a CAP and/or reconsideration request for a provider or supplier that has not been previously forwarded to PEOG by the MAC. The MAC shall not take any action on a provider or supplier's information on its enrollment record if there is a CAP and/or reconsideration request pending for a revocation action unless otherwise instructed by PEOG. The MAC shall email ProviderEnrollmentAppeals@cms.hhs.gov with any inquiries, questions, or requests.

All documentation related to CAPs and reconsideration requests (including, but not limited to, the decisions) shall be saved in PDF format. The date on the CAP and reconsideration request decisions should be the same date as the date the decision is issued to the provider/supplier/representative.

2. Reopening and Revising CAP and Reconsideration Determinations

Once a CAP and/or reconsideration decision is issued, the MAC shall not reopen and revise a CAP and/or reconsideration decision without PEOG's prior approval, even if the MAC rendered the CAP or reconsideration decision independently. The MAC shall send all requests to reopen and revise a CAP and/or reconsideration decision to ProviderEnrollmentAppeals@cms.hhs.gov and await further instruction before taking any action regarding the CAP and/or reconsideration decision.

3. Requests to the MACs

The MAC shall work with and provide PEOG and the Office of General Counsel (OGC), when applicable, all necessary documentation related to any and all CAPs, reconsideration requests, ALJ appeals, DAB appeals, or requests for judicial review.

The following are examples of information the MAC may be asked to provide. This is not an exhaustive list.

- *A copy of the initial determination letter;*
- *A chronological timeline outlining: (1) the processing of applications; (2) the date they began providing services at the newest assigned location; and (3) if there were development requests;*
- *The hearing officer's decision as well as the provider or supplier's CAP and/or reconsideration request;*
- *A complete copy of all application Form CMS-855s, and any supporting documentation submitted with the provider or supplier's application;*
- *All background information and investigative data the hearing officer used to make their decision. Including any on-site visit reports; the MAC's recommendation for administrative action based on the on-site visit;*
- *Contact information for the person(s) who signed both the revocation and reconsideration decision letters.*

The MAC shall supply PEOG or OGC with all requested documentation within 5 business days of receipt of the request, unless requested sooner.

All requested documentation shall be provided in PDF format (if possible) and saved with a file name that identifies the content of the document.

If a CAP and/or reconsideration decision requires the MAC to take action on a provider's or supplier's enrollment, such as reinstating the provider's or supplier's enrollment to an active status, the MAC shall complete all updates to the provider's or supplier's enrollment within 10 business days of the date the CAP and/or reconsideration decision is issued unless additional documentation is needed to update the enrollment. If a CAP or reconsideration decision requires the provider or supplier to submit further information before the enrollment can be updated, such as an enrollment application, the MAC shall allow 30 calendar days for the provider or supplier to submit the necessary information. The MAC shall complete all updates to the provider's or supplier's enrollment within 10 business days of the date of receipt of the additional information/documentation. If the provider or supplier does not submit the necessary information within 30 calendar days, the MAC shall contact PEOG by emailing ProviderEnrollmentAppeals@cms.hhs.gov for further instruction.

4. Timing of CAP and Reconsideration Request Submissions

A provider or supplier who wishes to submit a CAP must file its request in writing within 35 calendar days of the date of the initial determination. A provider or supplier who wishes to submit a reconsideration request must file its request in writing within 65 calendar days of the date of the initial determination. The date on which CMS or the MAC receives the submission is considered to be the date of filing. See section D below for

information on calculating timely submissions.

The mailing and email address for all CAPs and reconsideration requests to be rendered by CMS identified in section 10.6.18(A) is:

*Centers for Medicare & Medicaid Services
Provider Enrollment & Oversight Group
Attn: Division of Compliance and Appeals
7500 Security Boulevard
Mailstop AR-18-50
Baltimore, MD 21244-1850
ProviderEnrollmentAppeals@cms.hhs.gov*

Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review, and may result in the dismissal of any untimely submitted reconsideration request. The time limit may be extended if good cause for late filing is shown. Good cause may be found when the record clearly shows or the party alleges and the record does not negate that the delay in filing was due to circumstances outside of the provider's or supplier's control such as the following:

- *Unusual or unavoidable circumstances, the nature of which demonstrate that the individual could not reasonably be expected to have been aware of the need to file timely; or*
- *Destruction by fire, or other damage, of the individual's records when the destruction was responsible for the delay in filing.*

If a reconsideration request is not timely filed, as required in 42 C.F.R. § 498.22, CMS will make a determination as to whether good cause exists. If a MAC receives an untimely CAP and/or reconsideration request that it believes is entitled to a good cause exception related to untimeliness, the hearing officer must request approval from PEOG by emailing ProviderEnrollmentAppeals@cms.hhs.gov with an explanation as to why good cause is believed to exist before making a finding of good cause or taking any other action regarding the CAP and/or reconsideration request. The MAC shall not take action on the CAP and/or reconsideration request until it receives a response from CMS regarding the good cause exception request.

5. Time Calculations

Per 42 C.F.R. § 498.22(b)(3), the date of receipt of an initial determination is presumed to be 5 calendar days after the date on the initial determination notice unless there is a showing that it was, in fact, received earlier or later.

A CAP must be received by the MAC or CMS within 35 calendar days of the date of the initial determination. A reconsideration request must be received by the MAC or CMS within 65 calendar days of the date of the initial determination. If the 35th day (for a CAP) or 65th day (for a reconsideration request), falls on a weekend, or Federally recognized holiday, the CAP and/or reconsideration request shall be considered timely filed if received on the next business day. In the case of an email submission of a CAP and/or reconsideration request, the filing date is

presumed to be the date of receipt of the email. Consider the following example:

An initial determination letter is dated April 1. The provider is presumed to have received the initial determination on April 6. The provider submits a CAP and/or reconsideration request by mail that is received on June 10, 65 calendar days after April 6. This is considered timely because it is presumed that the provider did not receive the initial determination letter until April 6.

It is the provider or supplier's responsibility to timely update its enrollment record to reflect any changes to the provider or supplier's enrollment information, including its correspondence address. Failure to timely update a correspondence address or other address included in the enrollment record does not constitute an "in fact" showing that an initial determination letter was received after the presumed date of receipt.

6. Signatures

A CAP and/or reconsideration request must be submitted in the form of a letter that is signed by the individual provider, supplier, the authorized or delegated official, or a properly appointed representative, as defined in 42 C.F.R. § 498.10. If the representative is an attorney, the attorney must include a statement that he or she has the authority to represent the provider or supplier. This statement is sufficient to constitute notice. If the representative is not an attorney, the provider or supplier must file written notice of the appointment of a representative with the contractor. This notice of appointment must be signed by the individual provider or supplier, or the authorized or delegated official. The signature need not be original and can be electronic.

Authorized or delegated officials for groups cannot sign and submit a CAP and/or reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her behalf.

(NOTE: The provider or supplier's contact person (as listed in section 13 of the Form CMS- 855) does not qualify as a "representative" for purposes of signing a reconsideration request without the requisite appointment statement and signature by the individual provider or supplier.)

If the CAP and/or reconsideration request is not appropriately signed or if a statement from the attorney or written notice of representation is not included in the submission, the MAC shall send a development request for a proper signature or the missing statement/written notice (using the applicable model letter) before dismissing the CAP and/or reconsideration request. The MAC shall allow 15 calendar days from the date of the development request letter for the CAP and/or reconsideration request submitter to respond to the development request.

If the CAP and/or reconsideration request submission is not appropriately signed and no response is timely received to the development request (if applicable), the MAC shall dismiss the CAP and/or reconsideration

request using the applicable model dismissal letter.

7. Representative for CAP and/or Reconsideration Request

Per 42 C.F.R. § 498.10, a provider or supplier may appoint as its representative any individual that is not disqualified or suspended from acting as a representative in proceedings before the Secretary of the Department of Health and Human Services or otherwise prohibited by law to engage in the appeals process. If this individual is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative. If the representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with CMS or the MAC. Once a representative has been properly appointed, the representative may sign and/or submit a CAP, reconsideration request, request for reversal, or a request for good cause exception on behalf of the provider or supplier.

8. Submission of Enrollment Application while a CAP and/or Reconsideration Request is Pending/Submission Timeframe has not Expired

If a provider or supplier's enrollment application is denied, the provider or supplier must wait until the time period in which to submit a CAP and/or reconsideration request has ended before submitting a new enrollment application, change of information, or provides any additional information to update their enrollment record. If the MAC receives an enrollment application, change of information, or additional information to update a provider's or supplier's enrollment record prior to the conclusion of the time period in which to submit a CAP and/or reconsideration request, the MAC shall return the application unless the application is received as part of the provider's or supplier's CAP and/or reconsideration request submission. The MAC shall not modify the enrollment record of a provider or supplier that currently has a pending CAP and/or reconsideration request for revocations or is still within the submission time period for denials unless instructed by CMS to do so. Any applications received while the provider or supplier is in a revoked status should be returned to the provider or supplier and not processed pursuant to Section 10.4(H)(1).

B. Corrective Action Plans (CAPs)

1. Background

A CAP is a plan that allows a provider or supplier an opportunity to demonstrate compliance by correcting the deficiencies (if possible) that led to the initial determination. CAPs may only be submitted in response to enrollment denials pursuant to 42 C.F.R. § 424.530(a)(1) and revocation of Medicare billing privileges pursuant to 42 C.F.R. § 424.535(a)(1).

2. Requirements for CAP Submission

CAP submission:

- (a) Must contain, at a minimum, verifiable evidence that the provider or supplier is in compliance with all applicable Medicare requirements;
- (b) Must be received within 35 calendar days from the date of the initial determination (see section 10.6.18(A)(4) for clarification on timing). The contractor shall accept a CAP via hard-copy mail, email, and/or fax;
- (c) Must be submitted in the form of a letter that is signed by the individual provider or supplier, the authorized or delegated official that has been reported within your Medicare enrollment record, or a properly appointed representative;
- (d) Should include all documentation and information the provider or supplier would like to be considered in reviewing the CAP.

(e) For denials, the denial must be based on 42 C.F.R. § 424.530(a)(1);

i. For denials based on multiple grounds of which one is § 424.530(a)(1), the CAP may only be accepted with respect to § 424.530(a)(1), but not with respect to the other grounds. If the provider or supplier submits a CAP that does not comply with this paragraph, the MAC shall address this in the acknowledgement email or letter sent to the provider or supplier using the model acknowledgement letter. (If multiple grounds are involved of which one is § 424.530(a)(1), the MAC shall:

A. Only consider the portion of the CAP pertaining to § 424.530(a)(1). The other denial bases may only be reviewed as a reconsideration.

(f) For revocations, the revocation must be based on 42 C.F.R. § 424.535(a)(1);

i. Consistent with § 405.809, CAPs for revocations based on grounds other than § 424.535(a)(1) shall not be accepted.

A. For revocations based on multiple grounds of which one is § 424.535(a)(1), the CAP may be accepted with respect to § 424.535(a)(1), but not with respect to the other grounds. If the provider or supplier submits a CAP that does not comply with this paragraph, the MAC shall address this in the acknowledgement email or letter sent to the provider or supplier using the model acknowledgement letter. (If multiple grounds are involved of which one is § 424.535(a)(1), the MAC shall:

1. Only consider the portion of the CAP pertaining to § 424.535(a)(1). The other revocation bases may only be reviewed as a reconsideration.

3. Receipt Acknowledgment of CAP

If the MAC receives an acceptable CAP for a provider or supplier, the MAC shall use the model acknowledgment letter to email (if a valid email address is available) and send a hard-copy letter to the address included on the CAP submission letter or if no address is listed on the CAP submission letter, then the return address on the envelope from which the CAP was submitted

within 14 calendar days of the date of receipt of the CAP, informing the provider, supplier, or its representative that a CAP decision will be rendered within 60 calendar days of the date of receipt of the CAP. If no address is listed in the CAP, then an acknowledgment letter should be sent to the correspondence address on the provider's or supplier's enrollment record.

If the provider's or supplier's CAP cannot be accepted due to untimeliness, an improper signature (including a failure to respond to development for the required statement or signed declaration from a representative), or any other reason, the MAC shall not send the provider or supplier an acknowledgment email or letter. Instead, the MAC shall dismiss the CAP using the applicable model dismissal letter.

4. Dismissing a CAP

A CAP shall be dismissed when the provider or supplier does not have the right to submit a CAP for the initial determination, or when the provider or supplier submitted the CAP improperly or untimely (see Section 10.6.18(B)(2)). As a result, the CAP shall not be reviewed. The MAC shall use the model dismissal letter when dismissing a CAP. All unacceptable CAPs shall be dismissed as soon as possible.

If a provider or supplier concurrently submits a CAP and reconsideration request, but the initial determination being appealed does not afford CAP rights or the CAP submission is untimely, the MAC shall dismiss the CAP using the No CAP Rights Dismissal Model Letter or Untimely CAP Dismissal Model Letter and review the reconsideration request in accordance with the instruction in Section 10.6.18(C).

5. CAP Analysis

The MAC shall only review the CAP as it relates to denial of enrollment pursuant to 42 C.F.R. § 424.530(a)(1) or a revocation of billing privileges pursuant to § 424.535(a)(1). The MAC must determine whether or not the information and documentation submitted with the CAP establishes that the provider or supplier has demonstrated compliance with all applicable Medicare rules and requirements by correcting the deficiency that led to the initial determination. If the MAC finds that the CAP corrects the deficiency that led to the initial determination, then the MAC shall overturn the initial determination as it relates to the denial reasons under 42 C.F.R. § 424.530(a)(1) or revocation under 42 C.F.R. § 424.535(a)(1). If the denial of enrollment is overturned completely, the MAC shall continue processing the previously denied enrollment application in accordance with standard processing procedures. If the revocation is overturned completely, the MAC shall reinstate the provider's or supplier's enrollment to an approved status based on the date the provider or supplier came into compliance. Consider the following example:

Example 1: A provider or supplier is denied enrollment under 42 C.F.R. § 424.530(a)(1) or revoked under 42 C.F.R. § 424.535(a)(1) because its required license has been suspended. The provider timely submits a CAP in which it provides evidence that its licensure has been reinstated and is currently active. After confirming the status of current licensure, the MAC should render a favorable CAP decision because the provider or supplier

has corrected the licensure issue that led to enrollment denial or revocation.

If the provider or supplier submitted a CAP for reasons in addition to 42 C.F.R. § 424.535(a)(1), the MAC shall include in the decision letter that the CAP was reviewed only in regards to the 42 C.F.R. § 424.535(a)(1) basis.

If the provider or supplier does not submit information that establishes compliance with all applicable Medicare rules and requirements by correcting the deficiency that led to the initial determination, the MAC need not contact the provider or supplier for the missing information or documentation. The MAC shall instead deny the CAP. Under 42 C.F.R. § 405.809(a)(2), with respect to the revocation basis, the supplier has only one opportunity to correct all deficiencies that served as the basis of its revocation through a CAP.

6. Processing and Approval of CAPs

The time to submit a reconsideration request continues to run even though the MAC has received a CAP and is reviewing the CAP. Therefore, the time period in which to submit a reconsideration request does not stop once a CAP is received and while the CAP is being reviewed. The provider or supplier must submit a reconsideration request within 65 days of the date of the initial determination, even if a CAP is timely submitted and accepted.

The hearing officer shall issue a written decision within 60 calendar days of the date of receipt of the accepted CAP. The hearing officer shall email and mail a hard copy of the CAP decision to the provider or supplier or the individual that submitted the CAP, unless an email address is unavailable or the email is returned, then only a hard copy letter shall be mailed to the return address on the reconsideration request/envelope or the mailing address on the provider's/supplier's enrollment record if no return address is included on the reconsideration request. The MAC should also send the CAP decision letter via fax if a valid fax number is available.

If the MAC approves a CAP, it shall notify the provider or supplier by issuing a favorable decision letter following the applicable model CAP letter. The MAC shall continue processing the enrollment application under standard processing timelines or restore billing privileges (as applicable) within 10 business days of the date of the CAP decision or the date of receipt of additional documentation, if needed.

For denials – and unless stated otherwise in another CMS directive or instruction – the effective date is the later of either the date of the filing of the enrollment application or the date on which services were first rendered. Consider the following examples:

a. Denials

A physician's initial enrollment application is denied on March 1, 2018. The physician submits a CAP showing that, as of March 20th, the physician was in compliance with all Medicare requirements. If the MAC or CMS approves the CAP, the effective date of for the physician's Medicare billing privileges should be March 20th, as that is the day on which the physician came into compliance with all Medicare requirements. The 30-day retrospective billing provision should not be

applied in this situation because the rule assumes that the provider was in compliance with Medicare requirements during the 30-day period. This was not the case here. The physician was not in compliance with all Medicare requirements until March 20.

b. Revocations

A physician's medical license is suspended on June 1st. The physician's Medicare enrollment is revoked under 42 C.F.R. § 424.535(a)(1) on June 15th. The physician then submits a CAP showing that, as of July 1st, the physician is currently licensed. If the MAC or CMS approves the CAP, the effective date for reactivation of the physician's Medicare billing privileges should be July 1st as that is the day on which physician came into compliance with all Medicare requirements. The 30-day retrospective billing provision does not apply in this situation.

The MAC shall ensure that the applicable CMS Regional Office is notified of the outcome of any CAP decision that involves the revocation of Medicare billing privileges for a certified provider or supplier.

If additional information/documentation is needed prior to reinstating the provider or supplier, the MAC shall document these next steps in their CAP decision letter. The MAC shall not reinstate the provider's or supplier's enrollment until the requested information is received and processed. If the additional information/documentation is not received within 30 calendar days of the date of the CAP decision letter, the MAC shall contact the provider or supplier via the applicable model letter to again request the additional information/documentation within 10 calendar days of not receiving a response. If no response is received within 30 calendar days of the second request for additional information/documentation, the MAC shall contact ProviderEnrollmentAppeals@cms.hhs.gov within 10 calendar days for further instruction.

7. Withdrawal of CAP

The provider, supplier, or the individual who submitted the CAP may withdraw the CAP at any time prior to the mailing of the CAP determination. The withdrawal of the CAP must be postmarked prior to the CAP determination date. The request to withdraw the CAP must be made in writing, signed, and filed with the MAC or CMS. If the MAC receives a request to withdraw a CAP, it shall send a letter or e-mail to the provider or supplier acknowledging receipt of the request to withdraw the CAP and advising that the request has been dismissed, utilizing the applicable model letter.

8. Concurrent Submission of CAP and Reconsideration Request

If a provider or supplier submits a CAP and a reconsideration request concurrently in response to any denial of enrollment under 42 C.F.R. § 424.530(a)(1) or any revocation of billing privileges under 42 C.F.R. § 424.535(a)(1), the MAC shall first process and make a determination regarding the CAP, only as it relates to the denial and/or revocation under 42 C.F.R. § 424.530(a)(1) or 42 C.F.R. § 424.535(a)(1). If the MAC renders a

favorable decision as it relates to 42 C.F.R. § 424.530(a)(1) or 42 C.F.R. § 424.535(a)(1), the MAC shall only render a reconsideration decision on the remaining authorities not addressed by the favorable CAP decision. Processing timelines still apply.

If a CAP and a reconsideration request (see Section 10.6.18(B)(8)below) are submitted concurrently, the MAC shall coordinate the review of the CAP and reconsideration request to ensure that the CAP is reviewed and a decision rendered before a reconsideration decision is rendered (if the initial determination is not resolved in its entirety by the CAP decision).

If the CAP is approved and resolves the basis for the initial determination in its entirety, the model CAP decision letter shall be sent to the provider or supplier with a statement that the reconsideration request will not be evaluated because the initial determination has been overturned. If the CAP decision does not fully resolve the initial determination or results in a gap in the provider's or supplier's billing privileges, the MAC shall also process the reconsideration request.

If the CAP is denied:

- There are no further appeal rights; therefore, the CAP decision cannot be appealed. As a result, do not include further appeal rights for a CAP only decision.*
- The MAC shall notify the provider or supplier of the denial of the CAP via the applicable CAP model letter.*
- The provider or supplier may continue with the appeals process if it has filed a reconsideration request or is preparing to submit such a request and has not exceeded the timeframe in which to do so.*
- The reconsideration request, if properly submitted, shall be processed.*

C. Reconsideration Requests

1. Background

A reconsideration request allows the provider or supplier an opportunity to demonstrate that an error was made in the initial determination at the time the initial determination was implemented. In contrast to a CAP, a reconsideration request does not allow a provider or supplier the opportunity to correct the deficiencies that led to the initial determination.

2. Requirements for Reconsideration Request Submission

- a. Must contain, at a minimum, state the issues, or the findings of fact with which the affected party disagrees, and the reasons for disagreement;*
- b. Must be received within 65 calendar days from the date of the initial determination (see Section 10.6.19(A)(4) for clarification on timing). The contractor shall accept a reconsideration request via hard-copy mail, email, and/or fax;*
- c. Must be submitted in the form of a letter that is signed by the individual*

provider or supplier, the authorized or delegated official that has been reported within your Medicare enrollment record, or a properly appointed representative;

d. Should include all documentation and information the provider or supplier would like to be considered in reviewing the reconsideration request;

3. Receipt Acknowledgement of Reconsideration Request

Upon receipt of a properly submitted reconsideration request, the MAC shall send an email (if a valid email address is available) and hard-copy letter, to the individual that submitted the reconsideration request to acknowledge receipt of the reconsideration request using the applicable model acknowledgment letter within 14 calendar days of the date of receipt of the reconsideration request. The MAC shall send a hard-copy letter to the address listed in the reconsideration request submission or the return address listed on the reconsideration request submission envelope if no address is included on the reconsideration request letter. If no address is listed in the reconsideration request or on the envelope, then an acknowledgment letter should be sent to the correspondence address on the provider's or supplier's enrollment record. In the acknowledgment letter/email (if applicable), the MAC shall advise the requesting party that the reconsideration request will be reviewed and a determination will be issued within 90 calendar days from the date of receipt of the reconsideration request. The MAC shall include a copy of the acknowledgment letter and email (if applicable) in the reconsideration file. If the reconsideration should have been submitted to CMS, the MAC shall not send the provider or supplier an acknowledgment email or letter. Instead, the MAC shall forward the appeal to CMS within 10 business days of the date of receipt of the reconsideration request (as specified in Section 10.6.18(A)(1)).

If the provider's or supplier's reconsideration request cannot be accepted due to untimeliness, an improper signature (including a failure to respond to development for the required statement or signed declaration from a representative, or any other reason), the MAC shall not send the provider or supplier an acknowledgment email or letter. Instead, the MAC shall dismiss the reconsideration request using the applicable model dismissal letter.

4. Reconsideration Determination

The MAC shall review all documentation in the record relevant to the initial determination and issue a written determination within 90 calendar days of the date of receipt of the accepted reconsideration request.

A proper reconsideration request must be received by the MAC or CMS within 65 calendar days of the date of the initial determination. Refer to Section 10.6.18(A)(4) for receipt date determinations. However, consistent with 42 C.F.R. § 498.24(a), the provider or supplier, may submit corrected, new, or previously omitted documentation or other facts in support of its reconsideration request at any time prior to the reconsideration decision being issued. The hearing officer must determine whether an error was made in the initial determination at the time the initial determination was implemented, based on all of the evidence presented. This includes:

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

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

5. Issuance of Reconsideration Determination

The hearing officer shall issue a written decision within 90 calendar days of the date of receipt of the accepted reconsideration request. The hearing officer shall email and mail a hard copy of the reconsideration decision to the provider or supplier or the individual that submitted the reconsideration request, unless an email address is unavailable or the email is returned, then only a hard copy letter should be mailed to the return address on the reconsideration request/envelope or the mailing address on the provider's/supplier's enrollment record if no return address is included on the reconsideration request. The MAC should also fax the CAP decision letter if a valid fax number is available. The reconsideration letter shall follow the applicable model letter and include:

- *The regulatory basis to support each reason for the initial determination;*
- *A summary of the documentation that the provider or supplier provided, as well as any additional documentation reviewed as part of the reconsideration process;*
- *The re-stated facts and findings, including the regulatory basis for the action as determined by the contractor in its initial determination;*
- *A clear explanation of why the hearing officer is upholding or overturning the initial determination in sufficient detail for the provider or supplier to understand the hearing officer's decision and, if applicable, the nature of the provider's or supplier's deficiencies. This explanation should reference the specific regulations and/or sub-regulations supporting the decision, as well as any documentation reviewed;*
- *If applicable, an explanation of how the provider or supplier does not meet the Medicare enrollment criteria or requirements;*
- *Further appeal rights, regardless of whether the decision is favorable or*

unfavorable, procedures for requesting an ALJ hearing, and the addresses to which the written appeal must be mailed or e-mailed. Further appeal rights shall only be provided for reconsideration decisions. There are no further appeals rights related to CAP decisions; and

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

Example 1: If a provider or supplier submits a reconsideration request in response to a revocation pursuant to 42 C.F.R. § 424.535(a)(5), the MAC shall review the initial determination, the enrollment application preceding the site visit, the site investigation report(s), the reconsideration request and supporting documentation, as well as any other relevant information, to determine if an error was made in the implementation of the initial determination (e.g., if an error was made during the site visit, or the site visit was conducted at the wrong location.) If the MAC finds that an error was made during the site visit, which found the provider or supplier to be non-operational, the MAC shall order an additional site visit. If an additional site visit is ordered, the MAC shall await the findings of the site investigator, via the site visit report, before issuing a reconsideration decision. If the site visit report finds the provider or supplier to be operational then the MAC shall overturn the revocation of the provider's or supplier's Medicare billing privileges as it relates to 42 C.F.R. § 424.535(a)(5) using the applicable model letter.

If the MAC overturns the initial determination, the MAC shall reinstate the provider's or supplier's billing privileges to an approved status as of the effective date determined in the reconsidered determination or continue processing the enrollment application (as applicable). Unless otherwise instructed by PEOG, the MAC shall only send the favorable reconsideration decision to the provider or supplier, authorized or delegated official, or its representative at the return address included on the reconsideration request. The reconsideration decision is sufficient for providing notice to the provider or supplier of the enrollment action being taken. All enrollment updates shall be completed within 10 business days of the date the reconsideration decision was issued or the date of receipt of additional documentation, if needed.

For initial enrollments, the effective date of Medicare billing privileges is based on the date the provider or supplier is found to be in compliance with all Medicare requirements or the receipt date of the application – subject, of course, to any applicable retrospective billing provisions. (See Section 10.6.2 of this chapter for more information.) The MAC shall use the receipt date of the reconsideration request as the receipt date entered in the Provider Enrollment, Chain and Ownership System (PECOS). For DMEPOS suppliers, the effective date is the date awarded by the NSC.

The MAC shall ensure that the applicable CMS Regional Office is notified of the outcome of any reconsideration decision that involves the revocation of Medicare billing privileges for a certified provider or supplier.

If additional information/documentation is needed prior to reinstating the provider or supplier, the MAC shall document these next steps in their reconsideration decision letter. The MAC shall not reinstate the provider's or supplier's enrollment until the requested information is received and processed. If the additional information/documentation is not received within 30 calendar days of the date of the reconsideration decision letter, the MAC shall contact the provider or supplier via the applicable model letter to again request the additional information/documentation within 10 calendar days of not receiving a response. If no response is received within 30 calendar days of the second request for additional information/documentation, the MAC shall contact ProviderEnrollmentAppeals@cms.hhs.gov within 10 calendar days for further instruction.

6. Withdrawal of Reconsideration Request

The provider, supplier, or the individual who submitted the reconsideration request may withdraw the reconsideration request at any time prior to the mailing of the reconsideration decision. The withdrawal of a reconsideration request must be postmarked prior to the reconsideration decision date. The request to withdraw the reconsideration request must be made in writing, signed, and filed with the MAC or CMS. If the MAC receives a request to withdraw a reconsideration request, it shall send a letter or e-mail to the provider or supplier acknowledging receipt of the request to withdraw the reconsideration request and advising that the request has been dismissed, utilizing the applicable model letter.

7. Requests for Reversal under 42 C.F.R. § 424.530(c)/424.535(e)

Under 42 C.F.R. § 424.530(c)/424.535(e), a provider or supplier may request reversal of a denial of enrollment or revocation of billing privileges if the denial or revocation was due to adverse activity (sanction, exclusion, or felony) against an owner, managing employee, or an authorized or delegated official; or a medical director, supervising physician, or other personnel of the provider or supplier furnishing Medicare reimbursable services. The revocation may be reversed, at the discretion of CMS, if the provider or supplier terminates and submits proof that it has terminated its business relationship with the individual against whom the adverse action is imposed within 30 days of the initial determination. Information that may provide sufficient proof includes, but is not limited to, state corporate filings, IRS documentation, sales contracts, termination letters, evidence of unemployment benefits, board governance documents, and payroll records.

If the MAC receives a CAP and/or reconsideration request from a provider or supplier to reverse or rescind a denial or enrollment or revocation due to the termination of the business relationship between the provider or supplier and the individual against whom the adverse action is imposed, the MAC shall not take any action. The MAC shall forward the CAP and/or reconsideration request to ProviderEnrollmentAppeals@cms.hhs.gov within 10 business days of receipt. The MAC shall not take any action pursuant to the request until further instruction is provided by CMS.

8. Not Actionable CAPs and Reconsideration Requests

If the issue in the initial determination is resolved prior to a CAP and/or

reconsideration decision being rendered, the basis of the initial determination may become moot and the CAP and/or reconsideration request will be not actionable. The MAC will be notified if an action has been taken that would render a CAP and/or reconsideration request not actionable as CMS would contact the MAC to rescind the revocation or reinstate the provider or supplier's Medicare billing privileges. If the MAC receives such a notification, then the MAC shall review to determine if a CAP and/or reconsideration request has become not actionable. If so, the MAC shall send a hard copy letter should be mailed to the return address on the CAP or reconsideration request, as well as the provider's or supplier's correspondence address using the applicable not actionable model letter. The MAC shall also send an email if a valid email address is available. The MAC may also send via fax if a valid fax number is available. The MAC shall attach a copy of the letter informing the provider or supplier of the enrollment action which led to the CAP and/or reconsideration request becoming not actionable. If there is a scenario not captured in the not actionable model letter and the MAC believes a CAP and/or reconsideration request has become not actionable, the MAC should email ProviderEnrollmentAppeals@cms.hhs.gov for guidance.

9. Requesting Guidance Related to CAPs and Reconsideration Requests

If the MAC encounters a situation that is not addressed by these instructions, the MAC shall contact the ProviderEnrollmentAppeals@cms.hhs.gov inbox for guidance before taking any action.

D. Further Appeal Rights for Reconsidered Determinations

1. Administrative Law Judge (ALJ) Hearing

The CMS or a provider or supplier dissatisfied with a reconsidered determination is entitled to review by an ALJ with the CRD DAB. The ALJ has delegated authority from the Secretary of the Department of Health and Human Services (DHHS) to exercise all duties, functions, and powers relating to holding hearings and rendering decisions. Such an appeal must be filed, in writing, within 60 days from receipt of the reconsideration decision. To request final ALJ review, the provider or supplier must file an appeal with the Civil Remedies Division of the Departmental Appeals Board within 60 calendar days after the date of receipt of this decision. A provider or supplier may file an appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at <https://dab.efile.hhs.gov/>.

To file a new appeal using DAB E-File, the provider or supplier must first register a new account by:

- (a) Clicking Register on the DAB E-File home page;*
- (b) Entering the information requested on the "Register New Account" form; and*
- (c) Clicking Register Account at the bottom of the form. If the provider or supplier has more than one representative, each representative must register separately to use DAB E-File on his/her/its behalf.*

The e-mail address and password provided during registration must be entered on the login screen at https://dab.efile.hhs.gov/user_sessions/new to

access DAB E-File. A registered user's access to DAB E-File is restricted to the appeals for which he or she is a party or authorized representative.

Once registered, a provider or supplier may file an appeal by logging in and:

- Clicking the File New Appeal link on the Manage Existing Appeals screen, and then clicking Civil Remedies Division on the File New Appeal screen; and*
- Entering and uploading the requested information and documents on the "File New Appeal – Civil Remedies Division" form.*

All documents must be submitted in PDF form. More detailed instructions on DAB E-File for CRD cases can be found by clicking the CRD E-File Procedures link on the File New Appeal Screen for CRD appeals.

Pursuant to 42 C.F.R. § 405.809(a)(2), a provider or supplier may not appeal an adverse determination for a CAP, if one was made.

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

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

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

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

The MAC shall complete all steps associated with the settlement or ALJ decision no later than 10 business days from the date it received PEOG's

specific instructions.

2. Departmental Appeals Board (DAB) Hearing

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

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

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

The MAC shall complete all steps associated with the DAB decision no later than 10 business days from the date it received PEOG's specific instructions.

3. Judicial Review

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

E. External Monthly Reporting Requirements for CAPs and Reconsideration Requests

Using the provider enrollment appeals reporting template, the MAC shall complete all columns listed for all appeal submissions (CAPs and reconsideration requests). No column should be left blank.

The response in column A labelled, "Initial Determination Type," should be one of the following:

- **Denial:** CAP or Reconsideration Request that challenges the denial of a Medicare enrollment application pursuant to 42 C.F.R. § 424.530(a)(1)-(11).
- **Revocation:** CAP or Reconsideration Request that challenges the

revocation of Medicare billing privileges or provider/supplier number pursuant to 42 C.F.R. § 424.535(a)(1)- (14).

- **Effective Date:** Reconsideration request that challenges an initial determination that establishes an effective date of participation in the Medicare program, including the effective date of reactivation after deactivation.

The response in Column H labelled, “Final Decision Result,” should be one of the following:

- 1. Not Actionable:** Appeal is no longer actionable (moot) because the basis for the initial determination has been resolved. (Ex: Fingerprints have received a passed designation, initial determination has been reopened and revised).
- 2. Favorable (to provider/supplier):** MAC has determined that an error was made in the implementation of the initial determination. Therefore, the initial determination was overturned and the enrollment record has been placed in approved status, the effective date modified, or application processing has continued.
- 3. Unfavorable (to provider/supplier):** MAC upholds the initial determination resulting in the enrollment remaining in a revoked or denied status, or the effective date remaining the same.
- 4. Dismissed:** The appeal does not meet the appeal submission requirements. (Ex: incorrect signature, untimely, not appealable, etc.)
- 5. Rescinded:** MAC has received instruction from CMS to rescind the initial determination and return the enrollment record to an approved status.
- 6. Withdrawn:** Provider/supplier has submitted written notice of its intent to withdraw its appeal (CAP or reconsideration request).

The reports shall be sent to CMS via email at ProviderEnrollmentAppeals@cms.hhs.gov no later than the 15th of each month; the report shall cover the prior month’s appeal submissions (e.g., the February report shall cover all January CAPs/reconsideration requests). If this day falls on a weekend or a holiday, the report must be submitted the following business day.

10.6.19 – Other Medicare Contractor Duties *(Rev. 10611; Issued: 03-19-21; Effective: 11-19-20; Implementation: 11-19-20)*

The contractor shall adhere to all of the instructions in this chapter 10 (hereafter generally referred to as “this chapter”) and all other CMS provider enrollment directives (e.g., Technical Direction letters). The contractor shall also assign the appropriate number of staff to the Medicare enrollment function to ensure that all such instructions and directives - including application processing timeframes and accuracy standards - are complied with and met.

A. Training

The contractor shall provide (1) training to new employees, and (2) refresher training (as necessary) to existing employees to ensure that each employee processes enrollment applications in a timely, consistent, and accurate manner. Training shall include, at a minimum:

- An overview of the Medicare program
- A review of all applicable regulations, manual instructions, and other CMS guidance
- A review of the contractor's enrollment processes and procedures
- Training regarding the Provider Enrollment, Chain and Ownership System (PECOS).

For new employees, the contractor shall also:

- Provide side-by-side training with an experienced provider enrollment analyst
- Test the new employee to ensure that he or she understands Medicare enrollment policy and contractor processing procedures, including the use of PECOS
- Conduct end-of-line quality reviews for 6 months after training or until the analyst demonstrates a clear understanding of Medicare enrollment policy, contractor procedures, and the proper use of PECOS.

For existing employees, periodic quality reviews and refresher trainings shall be performed by the contractor on a periodic basis.

B. PECOS

The contractor shall:

- Process all enrollment actions (e.g., initials, changes, revalidations, revocations, appeals, denials) through PECOS
- Deactivate or revoke the provider or supplier's Medicare billing privileges in the Multi-Carrier System or the Fiscal Intermediary Shared System only if the provider or supplier is not in PECOS, if the provider does not exist in MCS or FISS, prior to taking action contact CMS
- Close or delete any aged logging and tracking (L & T) records older than 120 days for which there is no associated enrollment application
- Participate in user acceptance testing for each PECOS release
- Attend scheduled PECOS training when requested
- Report PECOS validation and production processing problems through the designated tracking system for each system release
- Develop (and update as needed) a written training guide for new and current employees on the proper processing of Form CMS-855, CMS-20134 applications, opt out affidavits, and the appropriate entry of data into PECOS.

C. Customer Service

1. Responding to Provider Enrollment Inquiries

The contractor's customer service unit may handle provider enrollment inquiries that do not involve complex enrollment issues. Examples of inquiries that can be processed by customer service units include:

- Application status checks (e.g., "Has the contractor finished processing my application?") (The contractor may wish to establish electronic mechanisms by which providers can obtain updates on the status of their enrollment applications via the contractor's Web site or automated voice response (AVR)).
- Furnishing information on where to access the Form CMS-855 or CMS-20134 applications (and other general enrollment information) on-line
- Explaining to providers/suppliers which Form CMS-855 or CMS-20134 applications should be completed.

2. Contractor's Responsiveness to Inquiries

Excluding matters pertaining to application processing (e.g., development for missing data) and appeals (e.g., appeal of revocation), the contractor is encouraged to respond to all enrollment-related provider/supplier correspondence (e.g., e-mails, letters, telephone calls) within 30 business days of receipt.

D. Contractor Outreach to Providers

The contractor is strongly encouraged to establish e-mail "list serves" with the provider community to disseminate important information thereto, such as contractor address changes, new CMS enrollment policies or internal contractor procedures, reminders about existing policies, etc. By being proactive in distributing information to its providers and suppliers on a regular basis (e.g., weekly, bi-weekly), the contractor can reduce the number of policy inquiries it receives and help facilitate the submission of complete and accurate Form CMS-855 or CMS-20134 applications.

E. Encouraging Use of Internet-based PECOS

When a prospective provider or supplier contacts the contractor to obtain a paper enrollment Form CMS-855 or CMS-20134, the contractor shall encourage the provider or supplier to submit the application using Internet-based PECOS. The contractor shall also notify the provider or supplier of:

- The CMS Web site at which information on Internet-based PECOS can be found and at which the paper applications can be accessed (<https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index?redirect=/MedicareProviderSupEnroll/>).
- The contractor's address so that the applicant knows where to return the completed application.
- Any supporting documentation required for the applicant's provider/supplier type.
- Other required forms as described in sections above. Notification can be given in any manner the contractor chooses.

F. Adherence to Responsibilities Based Upon Jurisdiction

1. Audit and Claims Contractors

a. Background

For purposes of enrollment via the Form CMS-855A, there are generally two categories of contractors: audit contractors and claims contractors. The audit contractor enrolls the provider, conducts audits, etc. The claims contractor pays the provider's claims. In most cases, the provider's audit contractor and claims contractor will be the same. On occasion, though, they will differ. This can happen, for instance, with provider-based entities, whereby the parent provider's contractor (audit contractor) will process the provider's enrollment application and a different contractor will pay the provider's claims (claims contractor).

Should the audit and claims contractors differ, the audit contractor shall process all changes of information, including all Form CMS-588 changes. The audit contractor shall notify the applicant during the initial enrollment process that all future changes of information must be sent to the audit contractor, not the claims contractor. If the provider inadvertently sends a change request to the claims contractor, the latter shall return the application per section 10.4(H)(1) of this chapter.

b. Process

If the audit contractor approves the Form CMS-855A transaction in question (e.g., initial enrollment), it shall:

- (i) Send an e-mail to the claims contractor identifying the specific Form CMS-855A transaction involved and confirming that the information has been updated in the Provider Enrollment, Chain and Ownership System (PECOS). Pertinent identifying information, such as the provider name, CMS Certification Number and National Provider Identifier, shall be included in the e-mail notification. If the e-mail contains any supporting documentation that contains personal health information or personally identifiable information the audit contractor shall encrypt the e-mail prior to sending.
- (ii) As applicable, fax, mail, or email an encrypted copy of the submitted Form CMS-588 to the appropriate claims contractor.

Upon receipt of the e-mail notification, the claims contractor shall access PECOS, review the enrollment record, and, as needed, update its records accordingly.

The audit contractor shall keep all original copies of Form CMS-855A paperwork and supporting documentation, including all Form CMS-588s.

c. Tie-In/Tie-Out Notices and Approval Notices

If the provider's audit contractor and claims contractor are different, the audit contractor shall e-mail or fax a copy of all tie-in/tie-out notices and approval letters it receives to the claims contractor. This is to ensure that the claims contractor is fully aware of the RO's action, as some ROs may only send copies of tie-in/tie-out notices and approval letters to the audit contractor. If the audit contractor chooses, it can simply contact the claims contractor by phone or e-mail and ask if the latter received the tie-in notice.

Again, it is imperative that audit and claims contractors effectively communicate and coordinate with each other in all payment-related and program integrity matters involving the provider.

G. Online Presence – Web Sites

The contractor must provide a link to CMS' provider/supplier enrollment Web site located at <https://www.cms.gov/medicare/provider-enrollment-and-certification/medicareprovidersupenroll/index.html?redirect=/medicareprovidersupenroll/>.

The link shall: (1) be available on the contractor's existing provider outreach Web site (which should be an established sub-domain of the contractor's current commercial Web site), and (2) comply with the guidelines stated in the Provider/Supplier Information and Education Web site section (Activity Code 14101) under the Provider Communications (PCOM) Budget and Performance Requirements (BPRs). Bulletins, newsletters, seminars/workshops and other information concerning provider enrollment issues shall also be made available on the existing provider outreach Web site. All contractor Web sites must comply with section 508 of the Rehabilitation Act of 1973 in accordance with, 36 CFR §1194, and must comply with CMS' Contractor Website Standards and Guidelines posted on CMS's Web site.

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

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

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

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

H. Document Retention

The contractor shall maintain and store all documents relating to the enrollment of a provider into the Medicare program. These documents include, but are not limited to, Medicare enrollment applications and all supporting documents, attachments, correspondence and correspondence tracking documentation, and appeals submitted in conjunction with an initial enrollment, reassignment, change of enrollment, revalidation, etc.

Supporting documentation includes, but is not limited to:

- Copies of Federal, State and/or local (city/county) professional licenses, certifications and/or registrations;
- Copies of Federal, State, and/or local (city/county) business licenses, certifications and/or registrations;

- Copies of professional school degrees or certificates or evidence of qualifying course work;
- Copies of CLIA certificates and FDA mammography certificates;
- Copies of any entry found on the Medicare Exclusion Database (MED) report that leads to a provider or supplier's revocation, and;
- Copies of Centers for Disease Control and Prevention (CDC) Diabetes Prevention Recognition Program (DPRP) recognition letters or certificates indicating Full or MDPP preliminary recognition.

The contractor shall dispose of the aforementioned records as described below:

1. Provider/Supplier and Durable Medical Equipment Supplier Application

a. Rejected applications as a result of provider failing to provide additional information

Disposition: Destroy when 7 years old.

b. Approved applications of provider/supplier

Disposition: Destroy 15 years after the provider/supplier's enrollment has ended.

c. Denied applications of provider/supplier.

Disposition: Destroy 15 years after the date of denial.

d. Approved application of provider/supplier, but the billing number was subsequently revoked.

Disposition: Destroy 15 years after the billing number is revoked.

e. Voluntary deactivation of billing number

Disposition: Destroy 15 years after deactivation.

f. Provider/Supplier dies

Disposition: Destroy 7 years after date of death.

2. Electronic Mail and Word Processing System Copies

a. Copies that have no further administrative value after the recordkeeping copy is made. These include copies maintained by individuals in personal files, personal electronic mail directories, or other personal directories on hard disk or network drives, and copies on shared network drives that are used only to produce the recordkeeping copy.

Disposition: Delete within 180 days after the recordkeeping copy has been produced.

b. Copies used for dissemination, revision or updating that are maintained in addition to the recordkeeping copy.

Disposition: Delete when dissemination, revision, or updating is complete.

I. Keeping Record of Activities

To ensure that proper internal controls are maintained and that important information is recorded in case of potential litigation, the contractor shall maintain documentation as outlined in this section 10.6.19(H). CMS cannot stress enough how crucial it is for contractors to document their actions as carefully and thoroughly as possible.

The requirements in this section 10.6.19(H) are in addition to, and not in lieu of, all other documentation or document maintenance requirements that CMS has mandated.

J. Keeping Record of Written and Telephonic Communications

(For purposes of this section 10.6.19(H), “written correspondence” includes mailed, faxed, and e-mailed correspondence.)

K. Keeping Record of Written Correspondence

The contractor shall:

- Retain copies of all written correspondence pertaining to the provider, regardless of whether the correspondence was initiated by the contractor, the provider, CMS, State officials, etc.
- Document when it sends written correspondence to providers. For instance, if the contractor crafts an approval letter to the supplier dated March 1 but sends it out on March 3, the contractor shall note this in the file.
- Document all referrals to CMS, the UPIC, or the OIG

L. Keeping Record of Telephonic or Face-to-Face Contact

Telephonic or Face-to-Face Contact is hereafter referred to as “oral communication.”

The contractor shall document any and all actual or attempted oral communication with the provider, any representative thereof, or any other person or entity regarding a provider. This includes, but is not limited to, the following situations:

- Telephoning a provider about its application. (Even if the provider official was unavailable and a voice mail message was left, this must be documented.)
- Requesting information from the state or another contractor concerning the applicant or enrollee
- Contacting the UPIC for an update concerning a particular case
- Phone calls from the provider
- Conducting a meeting at the contractor’s headquarters/offices with officials from a hospital concerning problems with its application
- Telephoning PEOG or the RO (e.g., the RO’s survey and certification staff) and receiving instructions therefrom about a problem the contractor is having with an applicant or an existing provider

- Telephoning the provider's billing department with a question about the provider.

When documenting oral communications, the contractor shall indicate: (1) the time and date of the call or contact; (2) who initiated the contact; (3) who was spoken with; and (4) what the conversation pertained to. Concerning the last requirement, the contractor need not write down every word that was said during the conversation. Rather, the documentation should merely be adequate to reflect the contents of the conversation. The documentation can be crafted and stored electronically if the contractor can provide access within 24 hours upon request.

The documentation requirements in this subsection (A) only apply to enrolled providers and to providers that have already submitted an enrollment application. In other words, these documentation requirements go into effect only after the provider submits an initial application. To illustrate, if a hospital contacts the contractor requesting information concerning how it should enroll in the Medicare program, this need not be documented because the hospital has not yet submitted an enrollment application.

If an application is returned per section 10.4(H)(1) of this chapter, the contractor shall document this. The manner of documentation lies within the contractor's discretion.

M. Documenting Verification of Data Elements

Once the contractor has completed its review of the CMS-855, CMS-20134 applications,(e.g., approved/denied application, approved change request) and Opt Out Affidavits, it shall document that it has: (1) verified all data elements on the application, and (2) reviewed all applicable names on the above mentioned forms against the OIG/LEIE and the System for Access Management (SAM). It can be drafted in any manner the contractor chooses so long as it certifies that the above-mentioned activities were completed. The record can be stored electronically.

For each person or entity that appeared on the OIG/LEIE or SAM, the contractor shall document the finding via a screen printout. In all other situations, the contractor is not encouraged to document their reviews via screen printouts. Simply using the verification statement described above is sufficient. Although the contractor has the discretion to use screen prints if it so chooses, the verification statement is still required.

N. Release of Information

On October 13, 2006, CMS published System of Records Notice for the Provider Enrollment, Chain and Ownership System (PECOS) in the Federal Register. Consistent with this notice, once the provider has submitted an enrollment application (as well as after it has been enrolled), the contractor shall not release – either orally or in writing - provider-specific data to any outside person or entity, unless specified otherwise in this chapter. (Provider-specific data includes, but are not limited to, owners/managers, adverse legal history, practice locations, group affiliations, effective dates, etc.) Examples of outside persons or entities include, but are not restricted to, national or state medical associations or societies, clearinghouses, billing agents, provider associations, or any person within the provider's organization other than the provider's authorized official(s) (section 15 of the CMS-855 and CMS-20134), delegated official(s) (section 16), or contact persons (section 13). The only exceptions to this policy are:

- A routine use found in the aforementioned System of Records applies.

- The provider (or, in the case of an organizational provider, an authorized or delegated official): (1) furnishes a signed written letter on the provider's letterhead stating that the release of the provider data is authorized, and (2) the contractor has no reason to question the authenticity of the person's signature. The letter can be mailed, faxed, or emailed to the contractor.
- The release of the data is specifically authorized in some other CMS instruction or directive.

(These provisions also apply in cases where the provider requests a copy of any Form CMS-855 or CMS-20134 paperwork the contractor has on file.)

It is recommended that the contractor notify the provider of the broad parameters of the aforementioned policy as early in the enrollment process as possible.

- The following information shall be made available over-the-phone to a caller who is able to provide a provider/suppliers name, PTAN, TIN/SSN and NPI number. The caller does not need to be listed on the provider/supplier's enrollment record as a contact person:
 - Revalidation status (i.e., whether or not a provider/supplier has been revalidated),
 - Revalidation due date,
 - Revalidation approval date,
 - The specific information related to a revalidation development request, and
 - The date a provider/supplier was deactivated due to non-response to a revalidation or non-response to a development request.

In addition:

- When sending emails, the contractor shall not transmit sensitive data, such as social security numbers or employer identification numbers, without first encrypting the email.
- The contractor may not send PECOS screen printouts to the provider.
- With the exception of CMS-855S applications, if any contact person listed on a provider or supplier's enrollment record, requests a copy of a provider or supplier's Medicare approval letter or revalidation notice, the contractor shall send to the contact person via email, fax or mail. This excludes Certification Letters (Tie In notices), as the contractor is not responsible for generating these approvals.

O. Security

The contractor shall ensure that the highest level of security is maintained for all systems and its physical and operational processes, in accordance with the CMS/Business Partners Systems Security Manual (BPSSM) and the Program Integrity Manual.

Applications shall never be removed from the controlled area to be worked on at home or in a non-secure location. Additionally, provider enrollment staff must control and monitor all applications accessed by other contractor personnel.

All contractor staff shall be trained on security procedures as well as relevant aspects of the Privacy Act and the Freedom of Information Act. This applies to all management, users, system owners/managers, system maintainers, system developers, operators and administrators - including contractors and third parties - of CMS information systems, facilities, communication networks and information.

Note that these instructions are in addition to, and not in lieu of, all other instructions issued by CMS regarding security.

P. Contractor to Contractor Communications

Medicare contractors create Associate and Enrollment Records in the Provider Enrollment, Chain and Ownership System (PECOS). Ownership of an Associate or Enrollment Record belongs to the contractor within whose jurisdiction the provider/supplier is located. PECOS only permits the contractor that created the Associate or Enrollment Record (the “owning contractor”) to make updates, changes, or corrections to those records. (That is, the owning contractor is the only contractor that can make changes to the associate record.)

Occasionally, updates, changes, or corrections do not come to the owning contractor’s attention, but instead go to a different contractor. In those situations, the contractor that has been notified of the update/change/correction (the “requesting” contractor) must convey the changed information to the owning contractor so that the latter can update the record in PECOS.

The requesting contractor may notify the owning contractor via fax or email (encrypted if it contains personally identifiable information) of the need to update/change/correct information in a provider’s PECOS record. The notification must contain:

1. The provider’s legal business name, Provider Transaction Access Number, and National Provider Identifier; and
2. The updated/changed/corrected data (by including a copy of the appropriate section of the Form CMS-855 or CMS-20134).

Within 7 calendar days of receiving the requesting contractor’s request for a change to a PECOS record, the owning contractor shall make the change and notify the requesting contractor thereof via fax, e-mail, or telephone.

If the owning contractor is reluctant to make the change, it shall contact its CMS Provider Enrollment & Oversight Group (PEOG) BFL for guidance. Note that the owning contractor may ask the requesting contractor for any additional information about the provider it deems necessary (e.g., IRS documentation, licenses).

The owning contractor need not ask the provider for a Form CMS-855 or CMS-20134 change of information in associate profile situations. It can simply use the Form CMS-855 or CMS-20134 copy that the requesting contractor sent/faxed to the owning contractor. For instance, suppose Provider X is enrolled in two different contractor jurisdictions – A and B. The provider enrolled with “A” first; its legal business name was listed as “John Brian Smith Hospital.” It later enrolls with “B” as “John Bryan Smith Hospital.” “B” has verified that “John Bryan Smith Hospital” is the correct name and sends a request to “A” to fix the name. “A” is not required to ask the provider to submit a Form CMS-855A change of information. It can use the CMS-855A copy that it received from “B.”

Q. Establishment of Relationships

To the maximum extent possible, and to help ensure that it becomes aware of recent felony convictions of practitioners and owners of health care organizations, the contractor shall establish relationships with appropriate State government entities – such as, but not limited to, Medicaid fraud units, State licensing boards, and criminal divisions – designed to facilitate the flow of felony information from the State to the contractor. For instance, the contractor can request that the State inform it of any new felony convictions of health care practitioners.

R. Ongoing Monitoring Activities

1. Monitoring Information from State Licensing Boards

To help ensure that only qualified physicians and non-physician practitioners are enrolled in Medicare, the contractor shall undertake the activities described below.

For purposes of this section, the term “practitioner” includes both physicians and non-physician practitioners. In addition, the instructions in this section, apply only to these practitioners.

a. Monthly Reviews

No later than the 15th day of each month, the contractor shall review State licensing board information for each State within its jurisdiction to determine whether any of its currently enrolled practitioners have, within the previous 60 days:

- Had their medical license revoked, suspended or inactivated (due to retirement, death, or voluntary surrender of license);
- Otherwise lost their medical license or have had their licenses expire.
- For those practitioners who no longer have a valid medical license, the contractor shall take the necessary steps pursuant to guidance in this chapter.
- The mechanism by which the contractor shall perform these monthly licensure reviews lies within its discretion, though the most cost-effective method shall be used.

S. Regarding Potential Identity Theft or Other Fraudulent Activity

In conducting the verification activities described in section 10.6.19(H) of this chapter, if the contractor believes that a case of identity theft or other fraudulent activity likely exists (e.g., physician or practitioner indicates that he or she is not establishing a new practice location or changing his or her EFT information, and that the application submitted in his/her name is false), the contractor shall notify its CMS Provider Enrollment & Oversight Group Business Function Lead (PEOG BFL) immediately; the BFL will instruct the contractor as to what, if any, action shall be taken

T. Medicare Contractor Duties – Reporting Requirements

1. Contractor Reporting Requirements

a. Monthly Rebuttal Reporting Requirements

Using the rebuttal reporting template, the contractor shall complete all columns listed for all rebuttal submissions. No column should be left blank.

The response in the column labelled “Final Decision Result” should be one of the following:

- **Not Actionable:** *Rebuttal is no longer actionable (moot) because the basis for the deactivation has been resolved.*
- **Favorable (to provider/supplier):** *MAC has determined that an error was made in the implementation of the deactivation. Therefore, the deactivation was not justified and the enrollment record has been placed back into an approved status.*
- **Unfavorable (to provider/supplier):** *MAC has determined that the deactivation was justified and the enrollment record remains deactivated.*
- **Dismissed:** *The appeal does not meet the rebuttal submission requirements. (Ex: incorrect signature, untimely, not rebuttable, etc.*
- **Rescinded:** *MAC has received instruction from CMS to rescind the deactivation and return the enrollment record to an approved status.*
- **Withdrawn:** *Provider/supplier has submitted written notice of its intent to withdraw its rebuttal.*

The reports shall be sent to CMS via email at ProviderEnrollmentAppeals@cms.hhs.gov no later than the 15th of each month; the report shall cover the prior month’s rebuttal submissions (e.g., the February report shall cover all January rebuttals). If this day falls on a weekend or a holiday, the report must be submitted the following business day.

10.7.7 – Application Return and Rejection Model Letters **(Rev. 10611; Issued: 03-19-21; Effective: 11-19-20; Implementation: 11-19-20)**

A. Returned Application Letter

[month] [day], [year]

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

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

Dear [Provider/Supplier Name]:

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

[List all reasons for return]

If you would like to resubmit an application, you must complete a new Medicare enrollment application(s). Please address the above issues as well as

sign and date the new certification statement page on your resubmitted application(s).

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

1. Internet-based Provider Enrollment, Chain and Organization System (PECOS). Go to: <https://pecos.cms.hhs.gov/pecos/login.do>.

2. Paper application process: Download and complete the Medicare enrollment application(s) at <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/EnrollmentApplications.html>. DMEPOS suppliers should send the completed application to the National Supplier Clearinghouse (NSC).

Please return the completed application(s) to:

[Name of MAC]

[Address]

[City], ST [Zip]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name]

[Title]

[Company]

B. Model Rejection Letter

[month] [day], [year]

[Provider/Supplier Name]

[Address]

[City] ST [Zip]

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

Dear [Provider/Supplier Name]:

We received your Medicare enrollment application(s) on [Receipt Date]. We are rejecting your application(s) for the following reason(s):

[List all reasons for rejection]

If you would like to resubmit an application, you must complete a new Medicare enrollment application(s). Please address the above issues as well as sign and date the new certification statement page on your resubmitted application(s).

In compliance with Federal regulations found at 42 CFR §424.525, providers and suppliers are required to submit complete application(s) and all supporting documentation within 30 calendar days from the postmark date of the contractor request for missing/incomplete information.

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

1. Internet-based Provider Enrollment, Chain and Organization System (PECOS). Go to: <https://pecos.cms.hhs.gov/pecos/login.do>.

2. Paper application process: Download and complete the Medicare enrollment application(s) at <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/EnrollmentApplications.html>. DMEPOS suppliers should send the completed application to the National Supplier Clearinghouse (NSC).

Please return the completed application(s) to:

[Name of MAC]

[Address]

[City], ST [Zip]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name]

[Title]

[Company]

C. Rejection Letter for Locations That Do Not Meet the Distance Requirements

C

[Provider/Supplier Name]

[Address]

[City] ST [Zip]

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

Dear [Provider/Supplier Name]:

We received your Medicare enrollment application(s) to add a new provider-based location to your Critical Access Hospital enrollment on [date]. We are rejecting your application because the CMS Regional Office, Division of Survey and Certification (RO DSC) has found that your new location does not meet distance requirements found in 42 CFR 485.610(e)(2).

Please refer to communications from the RO DSC for instructions for your next steps regarding the new provider-based location.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name]

[Title]

[Company]

10.7.8 – Denial Model Letters

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

A. Denial Letter Guidance

The contractor must submit one or more of 14 primary denial citations as found in Section 10.4(H)(3) of this chapter into the appropriate section on the Model Denial Letter. Only the CFR citation and a short heading shall be cited for the primary denial reason.

- *The contractor may submit one or more denial reason, as appropriate. The denial reason(s) should state sufficient details so it is clear as to why the provider or supplier is being denied.*
- *Specific Denial Reasons may contain one or more of the following items:*
 - *A specific regulatory (CFR) citation.*
 - *Dates (of actions, suspensions, convictions, receipt of documents, etc.)*
 - *Pertinent details of action(s)*

National Supplier Clearinghouse (NSC) only language. All denial letters for the NSC shall replace the 1st paragraph of the model denial letter with the following text:

Your application to enroll in Medicare is denied. After reviewing your submitted application document(s), it was determined that per 42 CFR §405.800, 42 CFR §424.57, and 42 CFR §498.22, that you do not meet the conditions of enrollment or meet the requirements to qualify as a Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) provider or supplier for the following reason(s):

Exclusions and sanctions – the following two sentences should be REMOVED for all denial letters that DO NOT involve an exclusion or sanction action:

You may not appeal through this process the merits of any exclusion by another federal agency. Any further permissible administrative appeal

involving the merits of such exclusion must be filed with the federal agency that took the action.

For IDTF, DMEPOS, and MDPP providers and suppliers, each regulatory citation needs to be listed along with the specific regulatory language. For IDTF, the standards are found in 42 CFR §410.33(g) 1 through 17. For DMEPOS providers and suppliers, the standards are found in 42 CFR §424.57(c) 1 through 30. For MDPP suppliers, the standards are found in 42 CFR §424.205(d).

If a provider is being added to the CMS Preclusion List, the following should be inserted to the denial letter (should PEOG instruct the contractor to do so):

The Centers for Medicare & Medicaid Services (CMS) has been made aware of [Provider Name]'s [Date], felony conviction, as defined in 42 C.F.R. § 1001.2, for [reason] in violation of [Code] in the Court Name]. After reviewing the specific facts and circumstances surrounding [Jane Doe]'s felony conviction, CMS has determined that [Provider Name]'s felony conviction is detrimental to the best interests of the Medicare program and its beneficiaries.

Additionally, [Provider Name] will be placed on the CMS Preclusion List because [he/she] has been convicted of a felony, as described above, under Federal or State law, within the previous 10 years, that CMS deems detrimental to the best interests of the Medicare program. CMS may take this action regardless of whether you are or were enrolled in the Medicare program. This action is being taken pursuant to 42 C.F.R. §§ 422.2, 422.222, 423.100, and 423.120(c)(6).

The effective date of your inclusion on the Preclusion List is dependent upon the submission or non-submission of a reconsideration request (see below). If you do submit a reconsideration request and your inclusion on the Preclusion List is upheld, you will be added to the Preclusion List on the date of the reconsideration decision. If you do not submit a reconsideration request, you will be included on the Preclusion List 65 days after the date of this letter.

During the time period that your name will be included on the Preclusion List as listed above, any claims you submit for health care items or services furnished under a Medicare Advantage (MA) benefit may be denied. Additionally, any pharmacy claims submitted for Medicare Part D drugs that you prescribe may be rejected or denied. This means that your patients may not be able to receive coverage of their prescriptions using their Part D benefit at the pharmacy.

*The below appeal rights apply to both your denial and preclusion. If you choose to appeal, you **must** file an appeal to the denial and preclusion jointly.*

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination.

Reconsideration requests must:

- *Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.*

- *State the issues or findings of fact with which you disagree and the reasons for disagreement.*
- *Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.*
 - *If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.*
 - *If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.*
 - *Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her behalf.*

Providers and suppliers may:

- *Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.*
- *Include an email address if you want to receive correspondence regarding your appeal via email.*

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

*Centers for Medicare & Medicaid Services
Provider Enrollment & Oversight Group
Attn: Division of Compliance and Appeals
7500 Security Boulevard
Mailstop AR-18-50
Baltimore, MD 21244-1850*

Or emailed to:

ProviderEnrollmentAppeals@cms.hhs.gov

B. Model Denial Letter

[month] [day], [year]

*[Provider/Supplier Name]
[Address]*

[City] ST [Zip]

Reference # (Contractor Control Number or NPI)

Dear [Provider/Supplier Name]:

Your application to enroll in Medicare is denied for the following reason(s):

xx CFR §xxx.(x) [heading]

[Specific reason]

xx CFR §xxx.(x) [heading]

[Specific reason]

Right to Submit a Corrective Action Plan (CAP) and Reconsideration Request:

Corrective Action Plan: (Only if denied under 42 C.F.R. § 424.530(a)(1))

You may submit a corrective action plan (CAP) in response to the denial of an enrollment application under 42 C.F.R. § 424.530(a)(1). You may also request a reconsideration (described below). If your enrollment application was denied under authorities other than 42 C.F.R. § 424.530(a)(1), you may **only** submit a reconsideration request in response to those denial bases.

The CAP is an opportunity to demonstrate that you have corrected the deficiencies identified above and thereby, establish your eligibility to enroll in the Medicare program. (Optional Coversheet sentence: [To facilitate the processing of your CAP, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.]])

The CAP must:

- Be received in writing within 35 calendar days of the date of this letter and mailed to the address below or emailed to the address below;
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
 - If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
 - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.
 - Authorized or delegated officials for groups cannot sign and submit a CAP on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her behalf.
- Provide evidence to demonstrate that you are in compliance with Medicare requirements.

Please note that CAPs may not be appealed further to the Departmental Appeals Board. Further appeal rights do exist for reconsideration requests (described below). CAP requests should be sent to:

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

| | | |
|-------------------------|----------|---|
| <i>[Name of MAC]</i> | <i>o</i> | <i>Centers for Medicare & Medicaid Services</i> |
| <i>[Address]</i> | <i>o</i> | <i>Center for Program Integrity</i> |
| <i>[City], ST [Zip]</i> | <i>r</i> | <i>Provider Enrollment & Oversight Group</i> |
| | | <i>Attn: Division of Compliance and Appeals</i> |
| | | <i>7500 Security Boulevard</i> |
| | | <i>Mailstop AR-18-50</i> |
| | | <i>Baltimore, MD 21244-1850</i> |

Or emailed to:

[Insert MAC email address] or [ProviderEnrollmentAppeals@cms.hhs.gov]

Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. (Optional Coversheet sentence [To facilitate the processing of your reconsideration request, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.])

Reconsideration requests must:

- *Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.*
- *State the issues or findings of fact with which you disagree and the reasons for disagreement.*
- *Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.*
 - *If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.*
 - *If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.*
 - *Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her behalf.*

Providers and suppliers may:

- *Submit additional information with the reconsideration that may have a*

bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.

- *Include an email address if you want to receive correspondence regarding your appeal via email.*
- *(If denied under 42 C.F.R. § 424.530(a)(2)) Please note that you may not appeal through this process the merits of any exclusion by another Federal agency. Any further permissible administrative appeal involving the merits of such exclusion must be filed with the Federal agency that took the action.*

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

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

| | | |
|-------------------------|----------|---|
| <i>[Name of MAC]</i> | <i>o</i> | <i>Centers for Medicare & Medicaid Services</i> |
| <i>[Address]</i> | | <i>Center for Program Integrity</i> |
| <i>[City], ST [Zip]</i> | <i>r</i> | <i>Provider Enrollment & Oversight Group</i> |
| | | <i>Attn: Division of Compliance and Appeals</i> |
| | | <i>7500 Security Boulevard</i> |
| | | <i>Mailstop AR-18-50</i> |
| | | <i>Baltimore, MD 21244-1850</i> |

Or emailed to:

[Insert MAC email address] or [ProviderEnrollmentAppeals@cms.hhs.gov]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

*[Name]
[Title]
[Company]*

C. Denial Example Letters

Note that each example contains appeal rights for both CMS and the MAC, regardless of the example reason, so that the contractors may include the appropriate appeal address based on the provider or supplier type that has been denied.

1. Discipline Not Eligible Example

[month] [day], [year]

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

Reference # (Contractor Control Number or NPI)

Dear [Provider/Supplier Name]:

Your application to enroll in Medicare is denied for the following reason(s):

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

There is no statutory or regulatory basis which permits a Marriage and Family Therapist to enroll or receive payment in the Medicare Program.

Right to Submit a Corrective Action Plan (CAP) and Reconsideration Request:

Corrective Action Plan: (Only if denied under 42 C.F.R. § 424.530(a)(1))

You may submit a corrective action plan (CAP) in response to the denial of an enrollment application under 42 C.F.R. § 424.530(a)(1). You may also request a reconsideration (described below). If your enrollment application was denied under authorities other than 42 C.F.R. § 424.530(a)(1), you may only submit a reconsideration request in response to those denial bases.

The CAP is an opportunity to demonstrate that you have corrected the deficiencies identified above and thereby, establish your eligibility to enroll in the Medicare program. (Optional Coversheet sentence: [To facilitate the processing of your CAP, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.]])
The CAP must:

- *Be received in writing within 35 calendar days of the date of this letter and mailed to the address below or emailed to the address below;*
- *Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.*
 - *If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.*
 - *If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.*
 - *Authorized or delegated officials for groups cannot sign and submit a CAP on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her behalf.*

- *Provide evidence to demonstrate that you are in compliance with Medicare requirements.*

Please note that CAPs may not be appealed further to the Departmental Appeals Board. Further appeal rights do exist for reconsideration requests (described below). CAP requests should be sent to:

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

| | | |
|-------------------------|----------|---|
| <i>[Name of MAC]</i> | <i>o</i> | <i>Centers for Medicare & Medicaid Services</i> |
| <i>[Address]</i> | <i>o</i> | <i>Center for Program Integrity</i> |
| <i>[City], ST [Zip]</i> | <i>r</i> | <i>Provider Enrollment & Oversight Group</i> |
| | | <i>Attn: Division of Compliance and Appeals</i> |
| | | <i>7500 Security Boulevard</i> |
| | | <i>Mailstop AR-18-50</i> |
| | | <i>Baltimore, MD 21244-1850</i> |

Or emailed to:

[Insert MAC email address] or [ProviderEnrollmentAppeals@cms.hhs.gov]

Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. (Optional Coversheet sentence [To facilitate the processing of your reconsideration request, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.])

Reconsideration requests must:

- *Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.*
- *State the issues or findings of fact with which you disagree and the reasons for disagreement.*
- *Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.*
 - *If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.*
 - *If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.*
 - *Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her behalf.*

Providers and suppliers may:

- *Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.*
- *Include an email address if you want to receive correspondence regarding your appeal via email.*
- *(If denied under 42 C.F.R. § 424.530(a)(2)) Please note that you may not appeal through this process the merits of any exclusion by another Federal agency. Any further permissible administrative appeal involving the merits of such exclusion must be filed with the Federal agency that took the action.*

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

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

| | | |
|-------------------------|----------|---|
| <i>[Name of MAC]</i> | | <i>Centers for Medicare & Medicaid Services</i> |
| <i>[Address]</i> | <i>o</i> | <i>Center for Program Integrity</i> |
| <i>[City], ST [Zip]</i> | <i>r</i> | <i>Provider Enrollment & Oversight Group</i> |
| | | <i>Attn: Division of Compliance and Appeals</i> |
| | | <i>7500 Security Boulevard</i> |
| | | <i>Mailstop AR-18-50</i> |
| | | <i>Baltimore, MD 21244-1850</i> |

Or emailed to:

[Insert MAC email address] or [ProviderEnrollmentAppeals@cms.hhs.gov]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,
[Name]

[Title]
[Company]

2. Criteria for Eligible Discipline Not Met Example

[month] [day], [year]

[Provider/Supplier Name]

[Address]

[City] ST [Zip]

Reference # (Contractor Control Number or NPI)

Dear [Provider/Supplier Name]:

Your application to enroll in Medicare is denied for the following reason(s):

*42 CFR §424.530(a)(1) - Not in Compliance with Medicare Requirements
Per 42 CFR §410.75(b)(1)(i), the provider or supplier is not certified by a recognized national certifying body that has established standards for nurse practitioners.*

Right to Submit a Corrective Action Plan (CAP) and Reconsideration Request:

Corrective Action Plan: (Only if denied under 42 C.F.R. § 424.530(a)(1))

You may submit a corrective action plan (CAP) in response to the denial of an enrollment application under 42 C.F.R. § 424.530(a)(1). You may also request a reconsideration (described below). If your enrollment application was denied under authorities other than 42 C.F.R. § 424.530(a)(1), you may only submit a reconsideration request in response to those denial bases.

*The CAP is an opportunity to demonstrate that you have corrected the deficiencies identified above and thereby, establish your eligibility to enroll in the Medicare program. (Optional Coversheet sentence: [To facilitate the processing of your CAP, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.]])
The CAP must:*

- *Be received in writing within 35 calendar days of the date of this letter and mailed to the address below or emailed to the address below;*
- *Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.*
 - *If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.*
 - *If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.*
 - *Authorized or delegated officials for groups cannot sign and submit a CAP on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her behalf.*
- *Provide evidence to demonstrate that you are in compliance with*

Medicare requirements.

Please note that CAPs may not be appealed further to the Departmental Appeals Board. Further appeal rights do exist for reconsideration requests (described below). CAP requests should be sent to:

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

| | | |
|-------------------------|----------|---|
| <i>[Name of MAC]</i> | <i>o</i> | <i>Centers for Medicare & Medicaid Services</i> |
| <i>[Address]</i> | <i>r</i> | <i>Center for Program Integrity</i> |
| <i>[City], ST [Zip]</i> | | <i>Provider Enrollment & Oversight Group</i> |
| | | <i>Attn: Division of Compliance and Appeals</i> |
| | | <i>7500 Security Boulevard</i> |
| | | <i>Mailstop AR-18-50</i> |
| | | <i>Baltimore, MD 21244-1850</i> |

Or emailed to:

[Insert MAC email address] or [ProviderEnrollmentAppeals@cms.hhs.gov]

Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. (Optional Coversheet sentence [To facilitate the processing of your reconsideration request, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.]])

Reconsideration requests must:

- *Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.*
- *State the issues or findings of fact with which you disagree and the reasons for disagreement.*
- *Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.*
 - *If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.*
 - *If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.*
 - *Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her behalf.*

Providers and suppliers may:

- *Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.*
- *Include an email address if you want to receive correspondence regarding your appeal via email.*
- *(If denied under 42 C.F.R. § 424.530(a)(2)) Please note that you may not appeal through this process the merits of any exclusion by another Federal agency. Any further permissible administrative appeal involving the merits of such exclusion must be filed with the Federal agency that took the action.*

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

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

| | | |
|-------------------------|----------|---|
| <i>[Name of MAC]</i> | <i>o</i> | <i>Centers for Medicare & Medicaid Services</i> |
| <i>[Address]</i> | | <i>Center for Program Integrity</i> |
| <i>[City], ST [Zip]</i> | <i>r</i> | <i>Provider Enrollment & Oversight Group</i> |
| | | <i>Attn: Division of Compliance and Appeals</i> |
| | | <i>7500 Security Boulevard</i> |
| | | <i>Mailstop AR-18-50</i> |
| | | <i>Baltimore, MD 21244-1850</i> |

Or emailed to:

[Insert MAC email address] or [ProviderEnrollmentAppeals@cms.hhs.gov]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,
[Name]

[Title]
[Company]

3. Provider Standards Not Met Example

[month] [day], [year]

[Provider/Supplier Name]
[Address]

[City] ST [Zip]

Reference # (Contractor Control Number or NPI)

Dear IDTF Services, Inc.:

Your application to enroll in Medicare is denied for the following reason(s):

42 CFR §424.530(a)(5) - On-site Review - Requirements Not Met
Specifically, the following standards were not met:

42 CFR §410.33(g) 4 - Have all applicable diagnostic testing equipment available at the physical site excluding portable diagnostic testing equipment. A catalog of portable diagnostic equipment, including diagnostic testing equipment serial numbers, must be maintained at the physical site. In addition, portable diagnostic testing equipment must be available for inspection within two business days of a CMS inspection request. The IDTF must maintain a current inventory of the diagnostic testing equipment, including serial and registration numbers, provide this information to the designated fee-for-service contractor upon request, and notify the contractor of any changes in equipment within 90 days.

42 CFR §410.33(g) 9 - Openly post these [IDTF] standards for review by patients and the public

42 CFR §410.33(g) 11 - Have its testing equipment calibrated and maintained per equipment instructions and in compliance with applicable manufacturers suggested maintenance and calibration standards.

42 CFR §410.33(g) 12 - Have technical staff on duty with the appropriate credentials to perform tests. The IDTF must be able to produce the applicable Federal or State licenses or certifications of the individuals performing these services.

Right to Submit a Corrective Action Plan (CAP) and Reconsideration Request:

Corrective Action Plan: (Only if denied under 42 C.F.R. § 424.530(a)(1))

You may submit a corrective action plan (CAP) in response to the denial of an enrollment application under 42 C.F.R. § 424.530(a)(1). You may also request a reconsideration (described below). If your enrollment application was denied under authorities other than 42 C.F.R. § 424.530(a)(1), you may **only** submit a reconsideration request in response to those denial bases.

The CAP is an opportunity to demonstrate that you have corrected the deficiencies identified above and thereby, establish your eligibility to enroll in the Medicare program. (Optional Coversheet sentence: [To facilitate the processing of your CAP, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.]])
The CAP must:

- Be received in writing within 35 calendar days of the date of this letter

- and mailed to the address below or emailed to the address below;
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
 - If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
 - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.
 - Authorized or delegated officials for groups cannot sign and submit a CAP on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her behalf.
- Provide evidence to demonstrate that you are in compliance with Medicare requirements.

Please note that CAPs may not be appealed further to the Departmental Appeals Board. Further appeal rights do exist for reconsideration requests (described below). CAP requests should be sent to:

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

| | | |
|---|----------------|---|
| <p>[Name of MAC] [Address] [City], ST [Zip]</p> | <p>o r</p> | <p><i>Centers for Medicare & Medicaid Services Center for Program Integrity Provider Enrollment & Oversight Group Attn: Division of Compliance and Appeals 7500 Security Boulevard Mailstop AR-18-50 Baltimore, MD 21244-1850</i></p> |
|---|----------------|---|

Or emailed to:

[Insert MAC email address] or [ProviderEnrollmentAppeals@cms.hhs.gov]

Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. (Optional Coversheet sentence [To facilitate the processing of your reconsideration request, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.]])

Reconsideration requests must:

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the

reasons for disagreement.

- *Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.*
 - *If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.*
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 - *Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her behalf.*

Providers and suppliers may:

- *Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.*
- *Include an email address if you want to receive correspondence regarding your appeal via email.*
- *(If denied under 42 C.F.R. § 424.530(a)(2)) Please note that you may not appeal through this process the merits of any exclusion by another Federal agency. Any further permissible administrative appeal involving the merits of such exclusion must be filed with the Federal agency that took the action.*

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

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

*[Name of MAC]
[Address]
[City], ST [Zip]*

*o
r*

*Centers for Medicare & Medicaid Services
Center for Program Integrity
Provider Enrollment & Oversight Group
Attn: Division of Compliance and Appeals
7500 Security Boulevard
Mailstop AR-18-50
Baltimore, MD 21244-1850*

Or emailed to:

[Insert MAC email address] or [ProviderEnrollmentAppeals@cms.hhs.gov]

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]

4. Business Type Not Met Example

[month] [day], [year]

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

Reference # (Contractor Control Number or NPI)

Dear [Provider/Supplier Name]:
Your application to enroll in Medicare is denied for the following reason(s):

42 CFR §424.530(a)(1) - Not in Compliance with Medicare Requirements
42 CFR §410.62(c)(ii) states that speech language pathologists in private practice must be engaged in one of the following practice types if allowed by State and local law: (A) An unincorporated solo practice; (B) An unincorporated partnership or unincorporated group practice; (C) An employee in an unincorporated solo practice, partnership, or group practice, or a professional corporation or other incorporated speech-language pathology practice; (D) An employee of a physician group (includes certain Non-Physician Practitioners [NPPs], as appropriate); or (E) An employee of a group that is not a professional corporation.

Your current private practice status is an incorporated solo practice; therefore, you do not qualify as a Medicare provider or supplier.

Right to Submit a Corrective Action Plan (CAP) and Reconsideration Request:

Corrective Action Plan: (Only if denied under 42 C.F.R. § 424.530(a)(1))

You may submit a corrective action plan (CAP) in response to the denial of an enrollment application under 42 C.F.R. § 424.530(a)(1). You may also request a reconsideration (described below). If your enrollment application was denied under authorities other than 42 C.F.R. § 424.530(a)(1), you may **only** submit a reconsideration request in response to those denial bases.

The CAP is an opportunity to demonstrate that you have corrected the deficiencies identified above and thereby, establish your eligibility to enroll in the Medicare program. (Optional Coversheet sentence: [To facilitate the

processing of your CAP, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.] The CAP must:

- Be received in writing within 35 calendar days of the date of this letter and mailed to the address below or emailed to the address below;
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
 - If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
 - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.
 - Authorized or delegated officials for groups cannot sign and submit a CAP on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her behalf.
- Provide evidence to demonstrate that you are in compliance with Medicare requirements.

Please note that CAPs may not be appealed further to the Departmental Appeals Board. Further appeal rights do exist for reconsideration requests (described below). CAP requests should be sent to:

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

| | | |
|--|--------|---|
| [Name of MAC] [Address] [City], ST [Zip] | o r | Centers for Medicare & Medicaid Services Center for Program Integrity Provider Enrollment & Oversight Group Attn: Division of Compliance and Appeals 7500 Security Boulevard Mailstop AR-18-50 Baltimore, MD 21244-1850 |
|--|--------|---|

Or emailed to:

[Insert MAC email address] or [ProviderEnrollmentAppeals@cms.hhs.gov]

Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. (Optional Coversheet sentence [To facilitate the processing of your reconsideration request, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.]])

Reconsideration requests must:

- *Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.*
- *State the issues or findings of fact with which you disagree and the reasons for disagreement.*
- *Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.*
 - *If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.*
 - *If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.*
 - *Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her behalf.*

Providers and suppliers may:

- *Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.*
- *Include an email address if you want to receive correspondence regarding your appeal via email.*
- *(If denied under 42 C.F.R. § 424.530(a)(2)) Please note that you may not appeal through this process the merits of any exclusion by another Federal agency. Any further permissible administrative appeal involving the merits of such exclusion must be filed with the Federal agency that took the action.*

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

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

*[Name of MAC]
[Address]
[City], ST [Zip]*

*o
r*

*Centers for Medicare & Medicaid Services
Center for Program Integrity
Provider Enrollment & Oversight Group*

*Attn: Division of Compliance and Appeals
7500 Security Boulevard
Mailstop AR-18-50
Baltimore, MD 21244-1850*

Or emailed to:

[Insert MAC email address] or [ProviderEnrollmentAppeals@cms.hhs.gov]

*If you have any questions, please contact our office at [phone number]
between the hours of [x:00 AM/PM] and [x:00 AM/PM].*

*Sincerely,
[Name]*

*[Title]
[Company]*

5. Existing or Delinquent Overpayments Example

[month] [day], [year]

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

Reference # (Contractor Control Number or NPI)

Dear [Provider/Supplier Name]:

*Your application to enroll in Medicare is denied for the following
reason(s):*

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

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

Dates: (enter date of existing or delinquent overpayment period)

*Pertinent details of action(s) (Whether the person or entity is on a
Medicare-approved plan of repayment of payments are currently being
offset; Whether the overpayment is currently being appealed; the reason
for the overpayment)*

**Right to Submit a Corrective Action Plan (CAP) and Reconsideration
Request:**

Corrective Action Plan: *(Only if denied under 42 C.F.R. § 424.530(a)(1))*

*You may submit a corrective action plan (CAP) in response to the denial of
an enrollment application under 42 C.F.R. § 424.530(a)(1). You may also
request a reconsideration (described below). If your enrollment application*

was denied under authorities other than 42 C.F.R. § 424.530(a)(1), you may **only** submit a reconsideration request in response to those denial bases.

The CAP is an opportunity to demonstrate that you have corrected the deficiencies identified above and thereby, establish your eligibility to enroll in the Medicare program. (Optional Coversheet sentence: [To facilitate the processing of your CAP, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.]])
The CAP must:

- Be received in writing within 35 calendar days of the date of this letter and mailed to the address below or emailed to the address below;
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
 - If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
 - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.
 - Authorized or delegated officials for groups cannot sign and submit a CAP on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her behalf.
- Provide evidence to demonstrate that you are in compliance with Medicare requirements.

Please note that CAPs may not be appealed further to the Departmental Appeals Board. Further appeal rights do exist for reconsideration requests (described below). CAP requests should be sent to:

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

[Name of MAC]

[Address]

[City], ST [Zip]

o

r

Centers for Medicare & Medicaid

Services

Center for Program Integrity

Provider Enrollment & Oversight Group

Attn: Division of Compliance and Appeals

7500 Security Boulevard

Mailstop AR-18-50

Baltimore, MD 21244-1850

Or emailed to:

[Insert MAC email address] or [ProviderEnrollmentAppeals@cms.hhs.gov]

Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. (Optional Coversheet sentence [To facilitate the processing of your reconsideration request, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.])

Reconsideration requests must:

- *Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.*
- *State the issues or findings of fact with which you disagree and the reasons for disagreement.*
- *Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.*
 - *If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.*
 - *If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.*
 - *Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her behalf.*

Providers and suppliers may:

- *Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.*
- *Include an email address if you want to receive correspondence regarding your appeal via email.*
- *(If denied under 42 C.F.R. § 424.530(a)(2)) Please note that you may not appeal through this process the merits of any exclusion by another Federal agency. Any further permissible administrative appeal involving the merits of such exclusion must be filed with the Federal agency that took the action.*

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

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

[Name of MAC]
[Address]
[City], ST [Zip]

o
r

*Centers for Medicare & Medicaid
Services
Center for Program Integrity
Provider Enrollment & Oversight Group
Attn: Division of Compliance and Appeals
7500 Security Boulevard
Mailstop AR-18-50
Baltimore, MD 21244-1850*

Or emailed to:

[Insert MAC email address] or [ProviderEnrollmentAppeals@cms.hhs.gov]

*If you have any questions, please contact our office at [phone number]
between the hours of [x:00 AM/PM] and [x:00 AM/PM].*

*Sincerely,
[Name]*

*[Title]
[Company]*

6. MDPP Supplier Standards Not Met – Ineligible Coach Example

[month] [day], [year]

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

Reference # (Contractor Control Number or NPI)

Dear [Provider/Supplier Name]:

*Your application to enroll in Medicare is denied for the following
reason(s):*

42 CFR §424.530(a)(1) - Not in Compliance with Medicare Requirements

Specifically, the following standards were not met:

*42 CFR §424.205(d)(3) - The MDPP supplier must not include on the
roster of coaches nor permit MDPP services to be furnished by any
individual coach who meets any of ineligibility criteria.*

*42 CFR §424.205(e)(v)(a) specifies that an individual with a state or
federal felony conviction in the previous 10 years of any crime against
persons, such as murder, rape, assault, and other similar crimes, would not
meet the eligibility criteria to be an MDPP coach.*

*The following coach included on Section 7 of your Form CMS-20134 or its
electronic equivalent meets this ineligibility criteria:*

John B. Doe / DOB: June 19, 1991 / NPI: 1234567

Please see attached documentation of the felony conviction.

Right to Submit a Corrective Action Plan (CAP) and Reconsideration Request:

Corrective Action Plan: (Only if denied under 42 C.F.R. § 424.530(a)(1))

You may submit a corrective action plan (CAP) in response to the denial of an enrollment application under 42 C.F.R. § 424.530(a)(1). You may also request a reconsideration (described below). If your enrollment application was denied under authorities other than 42 C.F.R. § 424.530(a)(1), you may only submit a reconsideration request in response to those denial bases.

The CAP is an opportunity to demonstrate that you have corrected the deficiencies identified above and thereby, establish your eligibility to enroll in the Medicare program. (Optional Coversheet sentence: [To facilitate the processing of your CAP, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.]])
The CAP must:

- *Be received in writing within 35 calendar days of the date of this letter and mailed to the address below or emailed to the address below;*
- *Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.*
 - *If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.*
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- *Provide evidence to demonstrate that you are in compliance with Medicare requirements.*

Please note that CAPs may not be appealed further to the Departmental Appeals Board. Further appeal rights do exist for reconsideration requests (described below). CAP requests should be sent to:

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

*[Name of MAC]
[Address]
[City], ST [Zip]*

*o
r*

*Centers for Medicare & Medicaid Services
Center for Program Integrity
Provider Enrollment & Oversight Group*

*Attn: Division of Compliance and Appeals
7500 Security Boulevard
Mailstop AR-18-50
Baltimore, MD 21244-1850*

Or emailed to:

[Insert MAC email address] or [ProviderEnrollmentAppeals@cms.hhs.gov]

Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. (Optional Coversheet sentence [To facilitate the processing of your reconsideration request, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.])

Reconsideration requests must:

- *Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.*
- *State the issues or findings of fact with which you disagree and the reasons for disagreement.*
- *Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.*
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 - *If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.*
 - *Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her behalf.*

Providers and suppliers may:

- *Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.*
- *Include an email address if you want to receive correspondence regarding your appeal via email.*
- *(If denied under 42 C.F.R. § 424.530(a)(2)) Please note that you may*

not appeal through this process the merits of any exclusion by another Federal agency. Any further permissible administrative appeal involving the merits of such exclusion must be filed with the Federal agency that took the action.

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

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

[Name of MAC] [Address] [City], ST [Zip] o r

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

Or emailed to:

[Insert MAC email address] or [ProviderEnrollmentAppeals@cms.hhs.gov]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

*Sincerely,
[Name]*

*[Title]
[Company]*

10.7.9 – Revocation Letters

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

A. Revocation Letter Guidance

The contractor:

- Must submit one or more of the Primary Revocation Reasons as found in section 10.4(M)(2) into the appropriate section on the specific Revocation Letter. Only the CFR citation and a short heading shall be cited for the primary revocation reason.*
- Shall include sufficient details to support the reason for the provider or supplier's revocation;*
- Shall issue all revocation letters via certified letter, per regulations found in 42 CFR 405.800(b)(1), and;*

- Shall issue two revocation letters to any solely owned organizations, one for the individual and the other for the organization.

B. Model Revocation Letters

1. Revocation Example - Letter for National Supplier Clearinghouse (NSC)

[month] [day], [year]

[Supplier Name]

[Address]

[City] ST [Zip]

Reference # (PTAN #, Enrollment #, Case #, etc.) Certified mail number:

[number]

Returned receipt requested

Dear [Supplier Name]:

The purpose of this letter is to inform you that pursuant to 42 CFR §§ 405.800, 424.57(x), 424.535(g), and 424.535(a)[(x)], your Medicare supplier number [xxxxxxxxxx] for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) issued by the National Supplier Clearinghouse (NSC)

[will be revoked effective 30 days from the postmarked date of this letter]

[is revoked. The effective date of this revocation has been made retroactive to [month] [day], [year], which is the date [revocation reason]]

Pursuant to 42 CFR §424.535(c), the supplier is barred from re-enrolling for a period of [number of years] year(s) in the Medicare program from the effective date of the revocation. In order to re-enroll, you must meet all requirements for your supplier type.

[The Supplier Audit and Compliance Unit (SACU) reviewed and evaluated the documents you submitted in response to the developmental letter dated [date]. This letter allowed you to demonstrate your full compliance with the DMEPOS supplier standards and/or to correct the deficient compliance requirement(s).]

[The Supplier Audit and Compliance Unit (SACU) has not received a response to the developmental letter sent to you on [date]. This letter allowed you to demonstrate your full compliance with the DMEPOS supplier standards and/or to correct the deficient compliance requirement(s)]

[The National Supplier Clearinghouse has not received a response to the developmental letter sent to you on [date] informing you that the request for a hardship exception for the required application fee was denied. The notification afforded you the opportunity to pay the mandatory application fee for processing your enrollment application and an appeal period which you did not select.]

[The National Supplier Clearinghouse has not received a response to the developmental letter sent to you on [date] informing you that the application fee was not paid at the time you filed the CMS 855S enrollment application. The 30day notification afforded you the opportunity to pay the mandatory application fee for processing your enrollment application]

We have determined that you are not in compliance with the supplier standards noted below:

42 CFR §424.579(c) [1-30] [Insert the specific performance standard not met]

Section 1834(j) of the Social Security Act states that, with the exception of medical equipment and supplies furnished incident to a physician's service, no payment may be made by Medicare for items furnished by a supplier unless the supplier has a valid Medicare billing number. Therefore, any expenses for items you supply to a Medicare beneficiary on or after the effective date of the revocation of your billing numbers are your responsibility and not the beneficiary's, unless you have proof that you have notified the beneficiary in accordance with section 1834 (a)(A)(ii) of the Social Security Act and the beneficiary has agreed to take financial responsibility if the items you supply are not covered by Medicare. You will be required to refund on a timely basis to the beneficiary (and will be liable to the beneficiary for) any amounts collected from the beneficiary for such items. If you fail to refund the beneficiary as required under 1834 (j) (4) and 1879(h) of the Social Security Act, you may be liable for Civil Monetary penalties.

You may not appeal through this process the merits of any exclusion by another Federal agency. Any further permissible administrative appeal involving the merits of such exclusion must be filed with the Federal agency that took the action.

Right to Submit a Corrective Action Plan (CAP) and Reconsideration Request:

Corrective Action Plan: (Only if denied under 42 C.F.R. § 424.530(a)(1))

You may submit a corrective action plan (CAP) in response to the denial of an enrollment application under 42 C.F.R. § 424.530(a)(1). You may also request a reconsideration (described below). If your enrollment application was denied under authorities other than 42 C.F.R. § 424.530(a)(1), you may only submit a reconsideration request in response to those denial bases.

The CAP is an opportunity to demonstrate that you have corrected the deficiencies identified above and thereby, establish your eligibility to enroll in the Medicare program. (Optional Coversheet sentence: [To facilitate the processing of your CAP, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.]]) The CAP must:

- *Be received in writing within 35 calendar days of the date of this letter and mailed to the address below or emailed to the address below;*
- *Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record,*

or an authorized representative.

- If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
- If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.
- Authorized or delegated officials for groups cannot sign and submit a CAP on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her behalf.
- Provide evidence to demonstrate that you are in compliance with Medicare requirements.

Please note that CAPs may not be appealed further to the Departmental Appeals Board. Further appeal rights do exist for reconsideration requests (described below). CAP requests should be sent to:

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

| | | |
|--|--------|--|
| [Name of MAC] [Address] [City], ST [Zip] | o r | <p>Centers for Medicare & Medicaid Services Center for Program Integrity Provider Enrollment & Oversight Group Attn: Division of Compliance and Appeals 7500 Security Boulevard Mailstop AR-18-50 Baltimore, MD 21244-1850</p> |
|--|--------|--|

Or emailed to:

[Insert MAC email address] or [ProviderEnrollmentAppeals@cms.hhs.gov]

Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. (Optional Coversheet sentence [To facilitate the processing of your reconsideration request, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.]])

Reconsideration requests must:

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record,

or an authorized representative.

- *If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.*
- *If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.*
- *Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her behalf.*

Providers and suppliers may:

- *Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.*
- *Include an email address if you want to receive correspondence regarding your appeal via email.*
- *(If denied under 42 C.F.R. § 424.530(a)(2)) Please note that you may not appeal through this process the merits of any exclusion by another Federal agency. Any further permissible administrative appeal involving the merits of such exclusion must be filed with the Federal agency that took the action.*

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

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

*[Name of MAC]
[Address]
[City], ST [Zip]*

*o
r*

*Centers for Medicare & Medicaid Services
Center for Program Integrity
Provider Enrollment & Oversight Group
Attn: Division of Compliance and Appeals
7500 Security Boulevard
Mailstop AR-18-50
Baltimore, MD 21244-1850*

Or emailed to:

[Insert MAC email address] or [ProviderEnrollmentAppeals@cms.hhs.gov]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name]
[Title]
[Company]

2. Model Revocation Letter for Part B Suppliers and Certified Providers and Suppliers

[Month] [day], [year]

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

Reference # (Contractor Control Number or NPI)

Dear [Provider/Supplier Name]:

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

xx CFR §xxx.(x) [heading]
[Specific reason]

xx CFR §xxx.(x) [heading]
[Specific reason]

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

Right to Submit a Corrective Action Plan (CAP) and Reconsideration Request:

Corrective Action Plan: (Only if revoked under 42 C.F.R. § 424.535(a)(1))

You may submit a corrective action plan (CAP) in response to the revocation of Medicare billing privileges under 42 C.F.R. § 424.535(a)(1). You may also request a reconsideration (described below). If your Medicare billing privileges were revoked under authorities other than 42 C.F.R. § 424.535(a)(1), you may **only** submit a reconsideration request in response to those revocation bases.

The CAP is an opportunity to demonstrate that you have corrected the deficiencies identified above and thereby, establish your eligibility to maintain enrollment in the Medicare program. (Optional Coversheet sentence [To facilitate the processing of your CAP, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.] The CAP must:

- Be received in writing within 35 calendar days of the date of this

letter and mailed or emailed to the address below;

- *Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.*
 - *If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.*
 - *If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.*
 - *Authorized or delegated officials for groups cannot sign and submit a CAP on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her behalf.*
- *Provide evidence to demonstrate that you are in compliance with Medicare requirements.*

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

The CAP should be sent to:

*[Name of MAC]
[Address] o
[City], ST [Zip] r*

*Centers for Medicare & Medicaid
Services
Center for Program Integrity
Provider Enrollment & Oversight Group
Attn: Division of Compliance and Appeals
7500 Security Boulevard
Mailstop AR-18-50
Baltimore, MD 21244-1850*

Or emailed to:

[Insert MAC email address] or [ProviderEnrollmentAppeals@cms.hhs.gov]

Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. (Optional Coversheet sentence [To facilitate the processing of your reconsideration request, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.]])

Reconsideration requests must:

- *Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.*

- *State the issues or findings of fact with which you disagree and the reasons for disagreement.*
- *Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.*
 - *If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.*
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 - *Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her behalf.*

Providers and suppliers may:

- *Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.*
- *Include an email address if you want to receive correspondence regarding your appeal via email.*
- *(If revoked under 42 C.F.R. § 424.535(a)(2)) Please note that you may not appeal through this process the merits of any exclusion by another Federal agency. Any further permissible administrative appeal involving the merits of such exclusion must be filed with the Federal agency that took the action.*

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

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

*[Name of MAC]
[Address]
[City], ST [Zip]*

*o
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*Centers for Medicare & Medicaid Services
Center for Program Integrity
Provider Enrollment & Oversight Group
Attn: Division of Compliance and Appeals
7500 Security Boulevard
Mailstop AR-18-50*

Baltimore, MD 21244-1850

Or emailed to:

[Insert MAC email address] or [ProviderEnrollmentAppeals@cms.hhs.gov]

Pursuant to 42 CFR §424.535(c), CMS is establishing a re-enrollment bar for a period of [Insert amount of time] that shall begin 30 days after the postmark date of this letter. This re-enrollment bar only applies to your ability to submit a new enrollment application to the Medicare program. In order to re-enroll, you must meet all requirements for your provider or supplier type.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name]
[Title]
[Company]

C. Revocation Letter Examples

Note that each example contains appeal rights for both CMS and the MAC, regardless of the example reason, so that the contractors may include the appropriate appeal address based on the provider or supplier type that has been revoked.

1. Abuse of Billing Revocation Letter Example

[month] [day], [year]

[Entity name]
[Address]
[City, State & ZIP Code]

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

Dear [Provider/Supplier Name]:

Your Medicare privileges are being revoked effective June 16, 2012 for the following reasons:

Revocation reason: 42 CFR §535(a)(8)

Specifically, you submitted 186 claims to Medicare for services provided after the date of death of 15 beneficiaries.

Right to Submit a Corrective Action Plan (CAP) and Reconsideration Request:

Corrective Action Plan: (Only if revoked under 42 C.F.R. § 424.535(a)(1))

You may submit a corrective action plan (CAP) in response to the

revocation of Medicare billing privileges under 42 C.F.R. § 424.535(a)(1). You may also request a reconsideration (described below). If your Medicare billing privileges were revoked under authorities other than 42 C.F.R. § 424.535(a)(1), you may only submit a reconsideration request in response to those revocation bases.

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 - Authorized or delegated officials for groups cannot sign and submit a CAP on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her behalf.
- Provide evidence to demonstrate that you are in compliance with Medicare requirements.

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

[Name of MAC]
[Address]
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Center for Program Integrity
Provider Enrollment & Oversight Group
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Mailstop AR-18-50
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[Insert MAC email address] or [ProviderEnrollmentAppeals@cms.hhs.gov]

Reconsideration Request:

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- *Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.*
- *Include an email address if you want to receive correspondence regarding your appeal via email.*
- *(If revoked under 42 C.F.R. § 424.535(a)(2)) Please note that you may not appeal through this process the merits of any exclusion by another Federal agency. Any further permissible administrative appeal involving the merits of such exclusion must be filed with the Federal agency that took the action.*

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights

can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

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

| | | |
|------------------|----------|--|
| [Name of MAC] | | Centers for Medicare & Medicaid |
| [Address] | <i>o</i> | Services |
| [City], ST [Zip] | <i>r</i> | Center for Program Integrity |
| | | Provider Enrollment & Oversight Group |
| | | Attn: Division of Compliance and Appeals |
| | | 7500 Security Boulevard |
| | | Mailstop AR-18-50 |
| | | Baltimore, MD 21244-1850 |

Or emailed to:

[Insert MAC email address] or [ProviderEnrollmentAppeals@cms.hhs.gov]

Pursuant to 42 CFR §424.535(c), CMS is establishing a re-enrollment bar for a period of [Insert amount of time] that shall begin 30 days after the postmark date of this letter. This re-enrollment bar only applies to your ability to submit a new enrollment application to the Medicare program. In order to re-enroll, you must meet all requirements for your provider or supplier type.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name]
[Title]
[Company]

2. DMEPOS Supplier Revocation Letter Example

[month] [day], [year]

[Entity name]
[Address]
[City, State & ZIP Code]

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

Dear [Supplier Name]:

The purpose of this letter is to inform you that pursuant to 42 CFR 405.800, 42 CFR 57(e), and 42 CFR 424.535(a)(5), your Medicare supplier number [98765432101] for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) issued by the National Supplier Clearinghouse (NSC) is revoked. The effective date of this revocation has been made retroactive to April 26, 2012, which is the date the Centers for Medicare & Medicaid Services (CMS) determined that your practice location is not operational.

Pursuant to 42 CFR 424.535(c), NSC is establishing a re-enrollment bar for a period of two (2) years from the effective date of the revocation. This enrollment bar applies only to your participation in the Medicare program. In order to re-enroll, you must meet all requirements for your supplier type. We have determined that you are not in compliance with the supplier standards noted below:

CFR 424.57(c) (7) Maintain a physical facility on an appropriate site, accessible to the public and staffed during posted hours of business with visible signage.

Recently a representative of the NSC attempted to conduct a visit of your facility on April 26, 2012. However, the visit was unsuccessful because your facility was closed, locked, and vacant. There was a "For Rent" sign on the window along with a sign directing customers to a nearby Rite Aid Pharmacy. Because we could not complete an inspection of your facility, we could not verify your compliance with the supplier standards. Based on a review of the facts, we have determined that your facility is not operational to furnish Medicare covered items and services. Thus, you are in violation of 42 CFR 424.535(a)(5).

CFR 424.57(c) (26) must meet the surety bond requirements specified in paragraph (d) of this section (CFR 424.57(d)).

We received a cancellation notice from Cook, Books & Hyde Surety indicating that the surety bond on file with the NSC number 99999999 has been cancelled effective January 19, 2012. You failed to maintain a valid surety bond as required by law.

Section 1834 (j) of the Social Security Act states that, with the exception of medical equipment and supplies furnished incident to a physician's service, no payment may be made by Medicare for items furnished by a supplier unless the supplier has a valid Medicare billing number. Therefore, any expenses for items you supply to a Medicare beneficiary on or after the effective date of the revocation of your billing numbers are your responsibility and not the beneficiary's, unless you have proof that you have notified the beneficiary in accordance with section 1834 (a) (18) (ii) of the Social Security Act and the beneficiary has agreed to take financial responsibility if the items you supply are not covered by Medicare. You will be required to refund on a timely basis to the beneficiary (and will be liable to the beneficiary for) any amounts collected from the beneficiary for such items. If you fail to refund the beneficiary as required under 1834 (j) (4) and 1879 (h) of the Social Security Act, you may be liable for Civil Monetary penalties.

If you believe that this determination is not correct, you may request a reconsideration before a contractor hearing officer. The reconsideration is an independent review and will be conducted by a person not involved in the initial determination. You must request the reconsideration in writing to this office within 60 calendar days of the postmark date of this letter. The reconsideration must state the issues or findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the reconsideration that you believe may have a bearing on the decision. The reconsideration must be signed and dated by the

authorized or delegated official within the entity. Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review.

In addition, if submitting a CMS 855S application after the re-enrollment bar has expired, 42 CFR 424.57(d)(3)(ii) states suppliers will be required to maintain an elevated surety bond amount of \$50,000 for each final adverse action imposed. Therefore, if you do not request a reconsideration of this decision or receive an unfavorable decision through the administrative review process, you must submit an elevated surety bond. Please note this amount is in addition to, and not in lieu of, the base \$50,000 amount that must be maintained.

The reconsideration request should be sent to:

*[National Supplier Clearinghouse Contractor name]
[Address]
[City], ST [Zip]*

If you choose not to request a reconsideration of this decision, or you do not receive a favorable decision through the administrative review process, you must wait two (2) year(s) before resubmitting your CMS-855S application, per the re-enrollment bar cited above. Applications received in the NSC prior to this timeframe will be returned.

If you have any questions, please contact our office at (866) 238-9652 between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

*[Name]
[Title]
[Company]*

3. MDPP Supplier Use of an Ineligible Coach Revocation Letter Example

[month] [day], [year]

*[Entity name]
[Address]
[City, State & ZIP Code]*

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

Dear [MDPP Supplier Name]:

Your Medicare privileges are being revoked effective June 16, 2018 for the following reasons:

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

Per 42 CFR §424.205(d)(3), MDPP suppliers must only use eligible coaches.

Revocation reason: 42 CFR §424.205(h)(v) – Use of an Ineligible coach

Specifically, you were notified on April 1, 2018 that John Doe was ineligible to serve as an MDPP coach due to an assault conviction in June 2015. On April 15, 2018, you submitted a corrective action plan (CAP), which removed John Doe from Section 7 of your Form CMS-20134. On June 1, 2018, you submitted a claim with the NPI of John Doe for services rendered May 1st, after he was removed from your coach roster. This indicates knowingly use of an ineligible MDPP coach.

Revocations under 42 CFR §424.205(h)(v) are not eligible for CAP submission. The revocation becomes effective 30 days after the date of this notice.

Right to Submit a Corrective Action Plan (CAP) and Reconsideration Request:

Corrective Action Plan: (Only if revoked under 42 C.F.R. § 424.535(a)(1))

You may submit a corrective action plan (CAP) in response to the revocation of Medicare billing privileges under 42 C.F.R. § 424.535(a)(1). You may also request a reconsideration (described below). If your Medicare billing privileges were revoked under authorities other than 42 C.F.R. § 424.535(a)(1), you may only submit a reconsideration request in response to those revocation bases.

The CAP is an opportunity to demonstrate that you have corrected the deficiencies identified above and thereby, establish your eligibility to maintain enrollment in the Medicare program. (Optional Coversheet sentence [To facilitate the processing of your CAP, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.] The CAP must:

- *Be received in writing within 35 calendar days of the date of this letter and mailed or emailed to the address below;*
- *Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.*
 - *If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.*
 - *If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.*
 - *Authorized or delegated officials for groups cannot sign and submit a CAP on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her behalf.*

- Provide evidence to demonstrate that you are in compliance with Medicare requirements.

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

[Name of MAC]
[Address]
[City], ST [Zip]

o
r

Centers for Medicare & Medicaid Services
Center for Program Integrity
Provider Enrollment & Oversight Group
Attn: Division of Compliance and Appeals
7500 Security Boulevard
Mailstop AR-18-50
Baltimore, MD 21244-1850

Or emailed to:

[Insert MAC email address] or [ProviderEnrollmentAppeals@cms.hhs.gov]

Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. (Optional Coversheet sentence [To facilitate the processing of your reconsideration request, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.]])

Reconsideration requests must:

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
 - If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
 - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.
 - Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her behalf.

Providers and suppliers may:

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.
- Include an email address if you want to receive correspondence regarding your appeal via email.
- (If revoked under 42 C.F.R. § 424.535(a)(2)) Please note that you may not appeal through this process the merits of any exclusion by another Federal agency. Any further permissible administrative appeal involving the merits of such exclusion must be filed with the Federal agency that took the action.

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

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

| | | |
|---|----------------|---|
| <p>[Name of MAC] [Address] [City], ST [Zip]</p> | <p>o r</p> | <p><i>Centers for Medicare & Medicaid Services Center for Program Integrity Provider Enrollment & Oversight Group Attn: Division of Compliance and Appeals 7500 Security Boulevard Mailstop AR-18-50 Baltimore, MD 21244-1850</i></p> |
|---|----------------|---|

Or emailed to:

[Insert MAC email address] or [ProviderEnrollmentAppeals@cms.hhs.gov]

Pursuant to 42 CFR §424.535(c), CMS is establishing a re-enrollment bar for a period of [Insert amount of time] that shall begin 30 days after the postmark date of this letter. This re-enrollment bar only applies to your ability to submit a new enrollment application to the Medicare program. In order to re-enroll, you must meet all requirements for your provider or supplier type.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name]
 [Title]
 [Company]

10.7.10 – Corrective Action Plan (CAP) Model Letters
(Rev. 10611; Issued: 03-19-21; Effective: 11-19-20; Implementation: 11-19-20)

A. CAP Withdrawn Acknowledgement Template

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

1. Email Template

To: [Email address provided by the person who submitted the CAP]

Subject: Medicare Provider Enrollment CAP re: [Provider/Supplier Name]

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

We are in receipt of your written withdrawal request in regard to your corrective action plan (CAP) received on [Month] [DD], [YYYY]. [MAC Name] has not yet issued a decision regarding your CAP. Therefore, [MAC Name] considers your CAP dated [Month] [DD], [YYYY] to be withdrawn. As a result, a decision will not be issued in response to your CAP.

If you have not yet filed a reconsideration request, please be advised that failure to timely submit a reconsideration request is deemed a waiver of all further administrative review.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address] [Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

2. Hard-Copy Letter Template

[Month] [DD], [YYYY]

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

Re: Corrective Action Plan Decision

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

NPI: [XXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXX] (optional)

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

We are in receipt of your written withdrawal request in regard to your corrective action plan (CAP) received on [Month] [DD], [YYYY]. [MAC Name] has not yet issued a decision regarding your CAP. Therefore, [MAC Name] considers your CAP dated [Month] [DD], [YYYY] to be withdrawn. As a result, a decision will not be issued in response to your CAP.

If you have not yet filed a reconsideration request, please be advised that failure to timely submit a reconsideration request is deemed a waiver of all further administrative review.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address] [Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)

*[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]*

B. CAP Receipt Acknowledgement Email Template to Provider/Supplier/Representative

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

1. Email Template

To: [Email address provided by the person who submitted the CAP]

Subject: Medicare Provider Enrollment CAP re: [Provider/Supplier Name]

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

We are in receipt of your corrective action plan (CAP) on behalf of [Provider/Supplier Name]. Please be advised that [MAC Name] has 60 calendar days to review your CAP and render a decision.

If you have additional information that you would like a hearing officer to consider during the CAP review you must submit that information prior to a decision being issued.

Please be advised that failure to timely submit a reconsideration request is deemed a waiver of all further administrative review.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address] [Call Center Telephone Number]

Sincerely

,

[Signature of Hearing Officer] (May be electronic)

*[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]*

2. Hard-Copy Letter Template

[Month] [DD], [YYYY]

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

*Re: Corrective Action Plan Decision
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)*

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

We are in receipt of your corrective action plan (CAP) on behalf of [Provider/Supplier Name]. Please be advised that [MAC Name] has 60 calendar days to review your CAP and render a decision.

If you have additional information that you would like a hearing officer to consider during the CAP review you must submit that information prior to a decision being issued.

Please be advised that failure to timely submit a reconsideration request is deemed a waiver of all further administrative review.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address] [Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)

*[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]*

C. CAP Decision Email Template to Provider/Supplier/Representative

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

To: *[Email address provided by the person who submitted the CAP]*

Subject: Medicare Provider Enrollment CAP re: [Provider/Supplier Name]

(Be sure to attach a copy of the final decision[s] in PDF format.)

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

Please see the attached decision regarding your Medicare Provider Enrollment CAP.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address] [Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]

[Position of Hearing Officer]

[MAC Name]

D. CAP Not Actionable (Moot) Model Letter

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of CAP]

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

[City], [State] [Zip Code]

Re: Corrective Action Plan Decision

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

NPI: [XXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXX] (optional)

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

This letter is in response to the CAP received by [MAC Name] based on the initial determination letter, dated [Month] [DD], [YYYY].

In correspondence dated [Month] [DD], [YYYY], the initial determination letter, dated [Month] [DD], [YYYY] informing you of the [denial of your Medicare enrollment application or revocation of your Medicare billing privileges] was [insert description] (describe action taken in regards to the initial determination, i.e. rescission of denial or revocation). For your convenience, a copy of the initial determination is included. Therefore, the issue set forth in the CAP is no longer actionable. This issue is moot, and we are unable to render a decision on the matter.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address] [Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]

[Position of Hearing Officer]

[MAC Name]

E. Untimely CAP Dismissal Model Letter

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of CAP]

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

[City], [State] [Zip Code]

Re: Corrective Action Plan Decision

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

NPI: [XXXXXXXXXX]

PTAN: [XXXXX]

Reference Number: [XXXX] (optional)

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

This letter is in response to the CAP received by [MAC Name] based on the initial determination letter, dated [Month] [DD], [YYYY].

[MAC Name] is unable to accept your CAP as it was not timely submitted. The initial determination letter was dated [Month] [DD], [YYYY]. A CAP must be received within 35 calendar days of the date of the initial determination letter. Your CAP was not received until [Month] [DD], [YYYY], which is beyond the applicable submission time frame. [Provider/Supplier/Representative] failed to show good cause for its late request. Therefore, [MAC Name] is unable to render a decision in this matter.

Please refer to the initial determination letter, dated [Month] [DD], [YYYY], for instructions on how to properly file a reconsideration request. If you have already submitted a reconsideration request, you will receive further communication related to that submission. Failure to timely file a reconsideration request is deemed a waiver of all further administrative review.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address] [Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)

*[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]*

F. Improperly Signed CAP Dismissal Model Letter

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [DD], [YYYY]

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

Re: Corrective Action Plan Decision

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

NPI: [XXXXXXXXXX]

PTAN: [XXXXX]

Reference Number: [XXXX] (optional)

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

This letter is in response to the corrective action plan (CAP) received by [MAC Name] based on the initial determination letter, dated [Month] [DD], [YYYY].

[MAC Name] is unable to accept your CAP as it was not signed by an authorized or delegated official currently on file in your Medicare enrollment record, the individual provider or supplier, or a properly appointed representative. The signature requirement was stated in the initial determination letter, dated [Month] [DD], [YYYY], as well as in Chapter 10 of the Medicare Program Integrity Manual.

Please refer to the initial determination letter, dated [Month] [DD], [YYYY], for instructions on how to properly file a reconsideration request. If you have already submitted a reconsideration request, you will receive further communication related to that submission. Failure to timely file a reconsideration request is deemed a waiver of all further administrative review.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address] [Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

G. No CAP Rights Dismissal Model Letter

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [DD], [YYYY]

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

*Re: Corrective Action Plan Decision
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)*

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

This letter is in response to the corrective action plan (CAP) received by [MAC Name] based on the initial determination letter, dated [Month] [DD], [YYYY].

[MAC Name] is unable to accept your CAP. A provider or supplier may only submit a CAP if there has been a denial of enrollment in the Medicare program under 42 C.F.R § 424.530(a)(1) or the revocation of Medicare billing privileges under 42 C.F.R. § 424.535(a)(1). Your enrollment was not denied or revoked under one of the aforementioned authorities. Therefore, a CAP decision cannot be rendered based on this submission.

Please refer to the initial determination letter, dated [Month] [DD], [YYYY], for instructions on how to properly file a reconsideration request. If you have already submitted a reconsideration request, you will receive further communication related to that submission. Please be advised that failure to timely submit a reconsideration request is deemed a waiver of all further administrative review.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address] [Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]

[MAC Name]

H. Not Eligible to Submit CAP Dismissal Model Letter

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of CAP]

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

[City], [State] [Zip Code]

Re: Corrective Action Plan Decision

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

NPI: [XXXXXXXXXX]

PTAN: [XXXXX]

Reference Number: [XXXX] (optional)

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

This letter is in response to the [corrective action plan (CAP)] received by [MAC Name], based on the [Month] [DD], [YYYY] initial determination.

[MAC Name] is unable to accept your [CAP] submission because the action taken in regards to your Medicare enrollment is not an initial determination subject to administrative review. More specifically, an initial determination has not been made as described in 42 C.F.R. § 498.3(b). Under 42 C.F.R. § 498.5(l), appeal rights extend only to initial determinations related to the denial or revocation of Medicare billing privileges.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address] [Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]

[Position of Hearing Officer]

[MAC Name]

I. CAP Signature Development Model Letter

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of CAP]

[Address] (Address from which the CAP was sent)
[City], [State] [Zip Code]

Re: Corrective Action Plan Decision

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

NPI: [XXXXXXXXXX]

PTAN: [XXXXX]

Reference Number: [XXXX] (optional)

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

We are in receipt of your CAP submission, received on [Month] [DD], [YYYY].

(If the submission is not properly signed, use the following.) [Your submission is not appropriately signed, as stated in the initial determination letter and in the Medicare Program Integrity Manual, Ch. 10, Section 10.6.18. [MAC Name] is requesting that you submit a CAP that is properly signed by the individual provider, supplier, the authorized or delegated official, or a properly appointed representative. Your properly signed submission must be received within 15 calendar days of the date of this notice. If you do not timely respond to this request, your CAP submission may be dismissed.]

(If the submission is missing a statement by the attorney, use the following.) [Your submission is missing an attorney statement that he or she has the authority to represent the provider or supplier. [MAC Name] is requesting that you submit a CAP that includes an attorney statement that he or she has the authority to represent the provider or supplier within 15 calendar days of the date of this notice. If you do not timely respond to this request, your CAP submission may be dismissed.]

(If the submission is missing a signed written notice from the provider/supplier authorizing the representative to act on his/her/its behalf, use the following.) [Your submission is missing a written notice of the appointment of a representative signed by the provider or supplier. [MAC Name] is requesting that you submit written notice of the appointment of a representative that is signed by the provider or supplier within 15 calendar days of the date of this notice. If you do not timely respond to this request, your CAP submission may be dismissed.]

Your submission should be sent to [MAC Appeal Receipt Email Address] or mailed to the following address:

[MAC Appeal Receipt Address] [MAC Fax number]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]

[Position of Hearing Officer]

[MAC Name]

J. Favorable CAP Model Letter in Response to an Enrollment Denial

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of CAP]

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

[City], [State] [Zip Code]

Re: Corrective Action Plan Decision

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

NPI: [XXXXXXXXXX]

PTAN: [XXXXX]

Reference Number: [XXXX] (optional)

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

This letter is in response to the corrective action plan (CAP) received by [MAC Name] based on an enrollment denial. The initial determination letter was dated [Month] [DD], [YYYY] and the CAP was received on [Month] [DD], [YYYY]; therefore, this CAP is considered timely. (if the CAP is untimely, but good cause has been found to accept the CAP, use the following [This CAP was not timely submitted, but a good cause waiver has been granted.] The following decision is based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

DENIAL REASON:

- *42 C.F.R. § 424.530(a)(1)*

OTHER APPLICABLE AUTHORITIES:

- *(Ex: Medicare Program Integrity Manual chapter 10, section 10.XX)*

EXHIBITS:

- *Exhibit 1: (Ex.: CAP, signed by Jane Doe, dated [Month] [DD], [YYYY].)*
- *Exhibit 2: (Ex: Copy of a medical license for Jane Doe from the Wisconsin Medical Board, effective [Month] [DD], [YYYY].)*

(In this section list each document submitted by the provider or supplier. Each exhibit should include the date, as well as a brief description of the document. You shall also include all other documentation not submitted by the provider that the hearing officer reviewed in making the decision, e.g., enrollment applications, development letters, etc.)

BACKGROUND:

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

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

CORRECTIVE ACTION PLAN ANALYSIS:

[A [Provider/Supplier Name] may only submit a corrective action plan for noncompliance under 42 C.F.R. § 424.530(a)(1). If the initial determination was based on any other denial reasons other than 42 C.F.R. § 424.530(a)(1), this decision will not review those authorities.]

(A CAP is an opportunity to correct the deficiencies identified in the initial determination. This section should include: A clear explanation of why the denial was overturned in sufficient detail for the provider or supplier to understand the decision and; if applicable: the nature of the provider or supplier's deficiencies, the regulatory or other policy basis to support each reason for the denial, and an explanation of how the provider or supplier now meets the enrollment criteria or requirements. This section shall not reference a CAP decision without explaining how and why you came to that decision.)

DECISION:

(A short conclusory restatement. Approval date should be based on the date the provider or supplier came into compliance with all applicable Medicare requirements.)

(Ex: On [Month] [DD], [YYYY], Jane Doe's medical license expired. However, on [Month] [DD], [YYYY] John Smith submitted a copy of his renewed medical license, which was reinstated back to the date of expiration by the Wisconsin Medical Board. As a result, [MAC Name] finds that Jane Doe came into compliance with the applicable Medicare requirements on [Month] [DD], [YYYY]. Therefore, [MAC Name] overturns the denial of Jane Doe's Medicare enrollment application as it relates to 42 C.F.R. § 424.530(a)(1).

*This decision is a **FAVORABLE DECISION**. To effectuate this decision, [MAC name] will continue processing the enrollment application.*

(If additional information is needed from the provider or supplier in order to reactivate the enrollment, the MAC shall state what information is needed from the provider or supplier in this CAP decision. MACs shall state that the requested information/documentation must be received within 30 calendar days of the date of this decision letter.)

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address] [Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

K. Favorable CAP Model Letter for Revocation Determination

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [DD], [YYYY]

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

*Re: Corrective Action Plan Decision
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)*

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

This letter is in response to the corrective action plan (CAP) received by [MAC Name] based on a revocation of Medicare billing privileges. The initial determination letter was dated [Month] [DD], [YYYY] and the CAP was received by [MAC Name] on [Month] [DD], [YYYY]; therefore, this appeal is considered timely. (if the CAP is untimely, but good cause has been found to accept the CAP, use the following [This CAP was not timely submitted, but a good cause waiver has been granted.]) The following decision is based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, evidence in the file, and any information received before this decision was rendered.

REVOCATION REASON:

- 42 C.F.R. § 424.535(a)(1)

OTHER APPLICABLE AUTHORITIES:

- (Ex: Medicare Program Integrity Manual chapter 10, section 10.XX)

EXHIBITS:

- *Exhibit 1: (Ex.: CAP, signed by Jane Doe, dated [Month] [DD], [YYYY].)*
- *Exhibit 2: (Ex: Copy of a medical license for Jane Doe from the Wisconsin Medical Board, effective [Month] [DD], [YYYY].)*

(In this section list each document submitted by the provider or supplier. Each exhibit should include the date, as well as a brief description of the document. You shall also include all other documentation not submitted by the provider

(that the hearing officer reviewed in making the decision, e.g., enrollment applications, development letters, etc.)

BACKGROUND:

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

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

CORRECTIVE ACTION PLAN ANALYSIS:

[A [Provider/Supplier Name] may only submit a corrective action plan for noncompliance. If the initial determination was based on revocation reasons other than 42 C.F.R. § 424.535(a)(1), this decision will not review those authorities.]

(A CAP is an opportunity to correct the deficiencies identified in the initial determination. This section should include: A clear explanation of why the revocation is being upheld or overturned in sufficient detail for the provider or supplier to understand the decision and; if applicable: the nature of the provider or supplier's deficiencies, the regulatory basis to support the revocation for noncompliance, and an explanation of how the provider or supplier now meets the enrollment compliance criteria or requirements. This section shall not reference a CAP decision without explaining how and why you came to that decision.)

DECISION:

(A short conclusory restatement.)

(Ex: On [Month] [DD], [YYYY], Jane Doe's medical license was suspended. However, as part of her CAP, Jane Doe submitted a revised order from the Wisconsin Medical Board, which reinstated her medical back license back to the date of suspension. As a result, [MAC Name] finds that Jane Doe came into compliance with the applicable Medicare requirements on [Month] [DD], [YYYY]. Therefore, [MAC Name] overturns the revocation of Jane Doe's Medicare billing privileges as it relates to 42 C.F.R. § 424.535(a)(1).

*This decision is a **FAVORABLE DECISION**. To effectuate this decision, [MAC name] [will reinstate/has reinstated] your Medicare billing privileges, effective [Month] [DD], [YYYY].*

(The reinstatement date is based on chapter 10 of the MPIM and the date of the provider's or supplier's revocation or the date the provider's or supplier's license was reinstated if the revocation involves a licensure issue.)

(If additional information is needed from the provider or supplier in order to reactivate the enrollment, the MAC shall state what information is needed from the provider or supplier in this CAP decision. MACs shall state that the requested information/documentation must be received within 30 calendar days of the date of this decision letter.)

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address] [Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

L. Unfavorable CAP Model Letter in Response to an Enrollment Denial

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [DD], [YYYY]

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

Re: Corrective Action Plan Decision

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

NPI: [XXXXXXXXXX]

PTAN: [XXXXX]

Reference Number: [XXXX] (optional)

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

This letter is in response to the corrective action plan (CAP) received by [MAC Name] based on an enrollment denial. The initial determination letter was dated [Month] [DD], [YYYY] and the CAP was received by [MAC Name] on [Month] [DD], [YYYY]; therefore, this appeal is considered timely. (if the CAP is untimely, but good cause has been found to accept the CAP, use the following [This CAP was not timely submitted, but a good cause waiver has been granted.] The following decision is based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

DENIAL REASON:

- 42 C.F.R. § 424.530(a)(1)

OTHER APPLICABLE AUTHORITIES:

- (Ex: Medicare Program Integrity Manual chapter 10, section 10.XX)

EXHIBITS:

- *Exhibit 1: (Ex.: CAP, signed by Jane Doe, dated [Month] [DD], [YYYY].)*
- *Exhibit 2: (Ex: Copy of a medical license for Jane Doe from the Wisconsin Medical Board, effective [Month] [DD], [YYYY].)*

(In this section list each document submitted by the provider or supplier. Each exhibit should include the date, as well as a brief description of the document. You shall also include all other documentation not submitted by the provider that the hearing officer reviewed in making the decision, e.g., enrollment applications, development letters, etc.)

BACKGROUND:

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

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

CORRECTIVE ACTION PLAN ANALYSIS:

[A [Provider/Supplier Name] may only submit a corrective action plan for noncompliance under 42 C.F.R. § 424.530(a)(1). If the initial determination was based on any other denial reasons other than 42 C.F.R. § 424.530(a)(1), this decision will not review those authorities.]

(A CAP is an opportunity to correct the deficiencies identified in the initial determination. This section should include: A clear explanation of why the denial is being upheld in sufficient detail for the provider or supplier to understand the decision and; if applicable: the nature of the provider or supplier's deficiencies, the regulatory or other policy basis to support each reason for the denial, and an explanation of how the provider or supplier now meets the enrollment criteria or requirements. This section shall not reference a CAP decision without explaining how and why you came to that decision.)

DECISION:

(A short conclusory restatement.)

(On [Month] [DD], [YYYY], Jane Doe's medical license was suspended by the Wisconsin Medical Board. [MAC Name] has confirmed that Jane Doe's medical license remains suspended. As a result, [MAC Name] upholds the denial of Jane Doe's Medicare enrollment application under 42 C.F.R. § 424.530(a)(1).)

*This decision is an **UNFAVORABLE DECISION**. [MAC name] concludes that the CAP does not correct the deficiencies that led to the denial of your Medicare enrollment. As a result, the denial of your Medicare enrollment is upheld.*

Failure to timely file a reconsideration request is deemed a waiver of all further administrative review. However, if you have submitted a reconsideration request, a separate decision is forthcoming.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address] [Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

M. Unfavorable CAP Model Letter for Revocation Determination

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [DD], [YYYY]

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

Re: Corrective Action Plan Decision

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

PTAN: [XXXX]

Reference Number: [XXXX] (optional)

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

This letter is in response to the corrective action plan (CAP) received by [MAC Name] based on a revocation of Medicare billing privileges. The initial determination letter was dated [Month] [DD], [YYYY] and the CAP was received by [MAC Name] on [Month] [DD], [YYYY]; therefore, this appeal is considered timely. (if the CAP is untimely, but good cause has been found to accept the CAP, use the following [This CAP was not timely submitted, but a good cause waiver has been granted.]) The following decision is based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

REVOCATION REASON:

- 42 C.F.R. § 424.535(a)(1)

OTHER APPLICABLE AUTHORITIES:

- (Ex: Medicare Program Integrity Manual chapter 10, section 10.XX)

EXHIBITS:

- *Exhibit 1: (Ex.: CAP, signed by Jane Doe, dated [Month] [DD], [YYYY].)*
- *Exhibit 2: (Ex: Copy of a medical license for Jane Doe from the Wisconsin Medical Board, effective [Month] [DD], [YYYY].)*

(In this section list each document submitted by the provider or supplier. Each exhibit should include the date, as well as a brief description of the document. You shall also include all other documentation not submitted by the provider that the hearing officer reviewed in making the decision, e.g., enrollment applications, development letters, etc.)

BACKGROUND:

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

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

CORRECTIVE ACTION PLAN ANALYSIS:

[A [Provider/Supplier Name] may only submit a corrective action plan for noncompliance. If the initial determination was based on revocation reasons other than 42 C.F.R. § 424.535(a)(1), this decision will not review those authorities.]

(A CAP is an opportunity to correct the deficiencies identified in the initial determination. This section should include: A clear explanation of why the revocation is being upheld in sufficient detail for the provider or supplier to understand the decision and; if applicable: the nature of the provider or supplier's deficiencies, the regulatory or other policy basis to support compliance and how the provider or supplier now meets the enrollment criteria or requirements. This section shall not reference a CAP decision without explaining how and why you came to that decision.)

DECISION:

(A short conclusory restatement.)

(On [Month] [DD], [YYYY], Jane Doe's medical license was suspended by the Wisconsin Medical Board. Jane Doe has not submitted evidence to demonstrate that her medical license has been reinstated. In addition, [MAC Name] has confirmed that Jane Doe's medical license remains suspended. As a result, [MAC Name] upholds the revocation of Jane Doe's Medicare billing privileges under 42 C.F.R. § 424.535(a)(1).)

*This decision is an **UNFAVORABLE DECISION**. [MAC name] concludes that the CAP did not correct the deficiencies noted in the implementation of the revocation. As a result, the revocation of your Medicare billing privileges is upheld.*

Failure to timely file a reconsideration request is deemed a waiver of all further administrative review. However, if you have submitted a reconsideration request, a separate decision is forthcoming.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address] [Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)

*[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]*

N. CAP Further Information Required for Development Model Letter

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

To: [Email address provided by the person who submitted the CAP.]

Subject: Medicare Provider Enrollment CAP re: [Provider/Supplier Name]

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

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

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

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

[City], [State] [Zip Code]

Re: CAP Decision

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

NPI: [XXXXXXXXXX]

PTAN: [XXXXX]

Reference Number: [XXXX] (Internal Tracking)

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

On [Month] [DD], [YYYY], [MAC Name] issued a CAP decision. As stated in the [Month] [DD], [YYYY] CAP decision letter, the approval of [Provider/Supplier Name]'s Medicare enrollment is contingent upon the submission of [list required documentation]. Please send the required documentation within 30 calendar days to:

[MAC CAP Receipt Address]

[MAC CAP Receipt Email Address] [MAC CAP Receipt Fax Number]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Signature of Hearing Officer] (May be electronic)

*[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]*

10.7.11 – Reconsideration Request Model Letters
(Rev. 10611; Issued: 03-19-21; Effective: 11-19-20; Implementation: 11-19-20)

A. Reconsideration Request Withdrawn Acknowledgement Template

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

1. Email Template

To: *[Email address provided by the person who submitted the reconsideration request]*

Subject: *Medicare Provider Enrollment Reconsideration Request re: [Provider/Supplier Name]*

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

We are in receipt of your written withdrawal request in regard to your reconsideration request received on [Month] [DD], [YYYY]. [MAC Name] has not yet issued a reconsidered decision, and therefore, [MAC Name] considers your reconsideration request to be withdrawn. As a result, a decision will not be issued in response to your reconsideration request.

Please be advised that failure to timely submit a reconsideration request is deemed a waiver of all further administrative review.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address] [Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)

*[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]*

2. Hard-Copy Letter Template

[Month] [Day], [YYYY]

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

Re: Reconsideration Request Decision
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXXX]
Reference Number: [XXXX] (optional)

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

We are in receipt of your written withdrawal request in regard to your reconsideration request received on [Month] [DD], [YYYY]. [MAC Name] has not yet issued a reconsidered decision, and therefore, [MAC Name] considers your reconsideration request to be withdrawn. As a result, a decision will not be issued in response to your reconsideration request.

Please be advised that failure to timely submit a reconsideration request is deemed a waiver of all further administrative review.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

*[MAC Appeal Receipt Address]
[Call Center Telephone Number]*

Sincerely,

[Signature of Hearing Officer] (May be electronic)

*[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]*

B. Reconsideration Request Receipt Acknowledgement Template to Provider/Supplier/Representative

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

1. Email Template

To: [Email address provided by the person who submitted the reconsideration request]

Subject: Medicare Provider Enrollment Reconsideration Request re: [Provider/Supplier Name]

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

We are in receipt of your reconsideration request on behalf of [Provider/Supplier Name]. Please be advised that [MAC Name] has 90

calendar days to review your reconsideration request and render a decision.

If you have additional information that you would like a hearing officer to consider during the reconsideration or, if necessary, an administrative law judge (ALJ) to consider during a hearing, you must submit that information to the hearing office before a decision is rendered. This is your only opportunity to submit information during the administrative appeals process; you will not have another opportunity to do so unless an ALJ specifically allows you to do so under 42 C.F.R. §498.56(e).

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address] [Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

2. Hard-Copy Letter Template

[Month] [Day], [YYYY]

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

Re: Reconsideration Request Decision
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

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

We are in receipt of your reconsideration request on behalf of [Provider/Supplier Name]. Please be advised that [MAC Name] has 90 calendar days to review your reconsideration request and render a decision.

If you have additional information that you would like a hearing officer to consider during the reconsideration or, if necessary, an administrative law judge (ALJ) to consider during a hearing, you must submit that information to the hearing office before a decision is rendered. This is your only opportunity to submit information during the administrative appeals process; you will not have another opportunity to do so unless an ALJ specifically allows you to do so under 42 C.F.R. §498.56(e).

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address] [Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]

[Position of Hearing Officer]

[MAC Name]

C. Reconsideration Request Decision Email Template to Provider/Supplier/Representative

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

To: [Email address provided by the person who submitted the Reconsideration Request]

Subject: Medicare Provider Enrollment Reconsideration Request re: [Provider/Supplier Name]

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

(Be sure to attach a copy of the final decision[s] in PDF format.)

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

Please see the attached decision regarding your Medicare Provider Enrollment Reconsideration Request.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address] [Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]

[Position of Hearing Officer]

[MAC Name]

D. Reconsideration Request Not Actionable (Moot) Model Letter

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [Day], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of Reconsideration Request]

[Address] (Address from which the Reconsideration Request was sent)
[City], [State] [Zip Code]

Re: Reconsideration Request Decision

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

NPI: [XXXXXXXXXX]

PTAN: [XXXXX]

Reference Number: [XXXX] (optional)

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

This letter is in response to the reconsideration request received by [MAC Name] based on the initial determination letter, dated [Month] [DD], [YYYY].

In correspondence dated [Month] [DD], [YYYY], the initial determination letter, dated [Month] [DD], [YYYY] informing you of the [denial of your Medicare enrollment application or revocation of your Medicare billing privileges] was [insert description] (describe action taken in regards to the initial determination, i.e. rescission of the denial or revocation). For your convenience, a copy of the initial determination is included. Therefore, the issue set forth in the reconsideration request is no longer actionable. This issue is moot, and we are unable to render a decision on the matter.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address] [Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]

[Position of Hearing Officer]

[MAC Name]

E. Untimely Reconsideration Request Dismissal Model Letter

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [Day], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of Reconsideration Request]

[Address] (Address from which the Reconsideration Request was sent)

[City], [State] [Zip Code]

Re: Reconsideration Request Decision

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

NPI: [XXXXXXXXXX]

PTAN: [XXXXX]

Reference Number: [XXXX] (optional)

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

This letter is in response to the reconsideration request received by [MAC Name], based on the initial determination letter dated [Month] [DD], [YYYY].

[MAC Name] is unable to accept your reconsideration request as it was not timely submitted. The initial determination letter was dated [Month] [DD], [YYYY]. A reconsideration request must be received within 65 calendar days of the date of the initial determination letter. Your reconsideration request was not received by [MAC Name] until [Month] [DD], [YYYY], which is beyond the applicable submission time frame. You have failed to show good cause for your late request. Therefore, [MAC Name] is unable to render a decision in this matter.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address] [Call Center Telephone Number]

Sincerely,

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

F. Improperly Signed Reconsideration Request Dismissal Model Letter

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [Day], [YYYY]

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

*Re: Reconsideration Request Decision
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)*

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

This letter is in response to the reconsideration request received by [MAC Name], based on the [Month] [DD], [YYYY] initial determination letter.

[MAC Name] is unable to accept your reconsideration request as it was not signed by an authorized or delegated official currently on file in your Medicare enrollment record, the individual provider or supplier, or a properly appointed representative. The signature requirement is stated in the [Month] [DD], [YYYY] initial determination letter, as well as in Chapter 10 of the Medicare Program Integrity Manual.

Please be advised that failure to timely submit a proper reconsideration request is deemed a waiver of all further administrative review.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address] [Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]

[Position of Hearing Officer]

[MAC Name]

G. Not Eligible to Submit Reconsideration Request Dismissal Model Letter

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [Day], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of Reconsideration Request]

[Address] (Address from which the Reconsideration Request was sent)

[City], [State] [Zip Code]

Re: Reconsideration Request Decision

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

NPI: [XXXXXXXXXX]

PTAN: [XXXXX]

Reference Number: [XXXX] (optional)

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

This letter is in response to the [reconsideration request] received by [MAC Name], based on the [Month] [DD], [YYYY] initial determination.

[MAC Name] is unable to accept your [reconsideration request] submission because the action taken in regards to your Medicare enrollment is not an initial determination subject to administrative review. More specifically, an initial determination has not been made as described in 42 C.F.R. § 498.3(b). Under 42 C.F.R. § 498.5(l), appeal rights related to provider enrollment extend only from initial determinations.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address] [Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]

[Position of Hearing Officer]

[MAC Name]

H. Reconsideration Request Signature Development Model Letter

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [Day], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of Reconsideration Request]

[Address] (Address from which the Reconsideration Request was sent)

[City], [State] [Zip Code]

Re: Reconsideration Request Decision

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

NPI: [XXXXXXXXXX]

PTAN: [XXXXX]

Reference Number: [XXXX] (optional)

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

We are in receipt of your reconsideration submission, received on [Month] [DD], [YYYY]. (If the submission is not properly signed, use the following.) [Your submission is not appropriately signed, as required in the Medicare Program Integrity Manual, Ch. 10, Section 10.6.18. [MAC Name] is requesting that you submit a reconsideration request that is properly signed by the individual provider, supplier, the authorized or delegated official, or a representative. Your properly signed submission must be received within 15 calendar days of the date of this notice. If you do not timely respond to this request, your reconsideration submission may be dismissed.]

(If the submission is missing a statement by the attorney, use the following.)

[Your submission is missing an attorney statement that he or she has the authority to represent the provider or supplier. [MAC Name] is requesting that you submit a rebuttal that includes an attorney statement that he or she has the authority to represent the provider or supplier within 15 calendar days of the date of this notice. If you do not timely respond to this request, your reconsideration submission may be dismissed.]

(If the submission is missing a signed written notice from the provider/supplier authorizing the representative to act on his/her/its behalf, use the following.)

[Your submission is missing a written notice of the appointment of a representative signed by the provider or supplier. [MAC Name] is requesting that you submit written notice of the appointment of a representative that is signed by the provider or supplier within 15 calendar days of the date of this notice. If you do not timely respond to this request, your reconsideration submission may be dismissed.]

Your submission should be sent to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address]
[MAC Fax number]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

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

I. Favorable Reconsideration Request Model Letter in Response to an Enrollment Denial

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [Day], [YYYY]

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

Re: Reconsideration Request Decision

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

NPI: [XXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXX] (optional)

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

This letter is in response to the reconsideration request received by [MAC Name] based on an enrollment denial. The initial determination letter was dated [Month] [DD], [YYYY] and the reconsideration request was received by [MAC Name] on [Month] [DD], [YYYY]; therefore, this reconsideration request is considered timely. (if the reconsideration request is untimely, but good cause has been found to accept the reconsideration request, use the following [This reconsideration request was not timely submitted, but a good cause waiver has been granted.]) The following decision is based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

DENIAL REASON(S):

- 42 C.F.R. § 424.530(a)(denial reason 1-14)
- 42 C.F.R. § 424.530(a)(denial reason 1-14)

OTHER APPLICABLE AUTHORITIES:

- 42 C.F.R. §
- (Ex: Medicare Program Integrity Manual (MPIM) chapter 10, section 10.XX)

EXHIBITS:

- Exhibit 1: (Ex.: Reconsideration request, signed by Jane Doe, dated [Month] [DD] [YYYY].)
- Exhibit 2: (Ex: Copy of a medical license for Jane Doe from the Wisconsin Medical Board, effective [Month] [DD], [YYYY].)

(In this section list each document submitted by the provider or supplier. Each exhibit should include the date, as well as a brief description of the document. You shall also include all other documentation not submitted by the provider that the hearing officer reviewed in making the decision, e.g., enrollment applications, development letters, etc.)

BACKGROUND:

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

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

RECONSIDERATION ANALYSIS:

(The hearing officer needs to check to determine if a CAP was also submitted and approved for this provider or supplier. If so, the reconsideration decision should only address the remaining authorities and use the following sentence, “[MAC Name] has approved the CAP submitted on [Month] [DD], [YYYY] in a decision dated [Month] [DD], [YYYY]. Therefore, this decision will only address the remaining denial reason(s) 42 C.F.R. § 424.530(a)(denial reason 1-14).)

(If the CAP resolves the denial in its entirety, the applicable moot model letter should be issued in response to the reconsideration request instead of this decision template.)

(A reconsideration request reviews whether or not an error was made at the time the initial determination was implemented. This section should summarize the statements made by the provider or supplier in its reconsideration request. Then conduct analysis of the arguments based on the applicable regulations and sub-regulations, MPIM. This section shall not reference a reconsideration decision without explaining how and why you came to that decision.)

DECISION:

(A short conclusory restatement.)

(Ex: On [Month] [DD], [YYYY], a disciplinary hearing was held regarding the medical license of Jane Doe. However, on [Month] [DD], [YYYY], the Wisconsin Medical Board declined to take disciplinary action against Jane Doe’s medical license. As a result, [MAC Name] overturns the denial of Jane Doe’s Medicare enrollment application as it relates to 42 C.F.R. §

424.530(a)(1).

*This decision is a **FAVORABLE DECISION**. To effectuate this decision, [MAC name] will continue processing the enrollment application.*

(If additional information is needed from the provider or supplier in order to reactivate the enrollment, the MAC shall state what information is needed from the provider or supplier in this reconsideration decision. MACs shall state that the requested information/documentation must be received within 30 calendar days of the date of this decision letter.)

FURTHER APPEAL RIGHTS - ADMINISTRATIVE LAW JUDGE (ALJ):

If you are satisfied with this decision, you do not need to take further action. If you believe that this determination is not correct, you may request ALJ review for the reconsideration portion of this decision letter. To request ALJ review, you must file your appeal with the Civil Remedies Division of the Departmental Appeals Board within 60 calendar days after the date of receipt of this decision.

How to file a hearing request

You can file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at <https://dab.efile.hhs.gov/>.

To file a new appeal using DAB E-File, you first need to register a new account by:

- 1. Clicking Register on the DAB E-File home page;*
- 2. Entering the information requested on the “Register New Account” form; and*
- 3. Clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.*

The e-mail address and password provided during registration must be entered on the login screen at https://dab.efile.hhs.gov/user_sessions/new to access DAB E-File. A registered user’s access to DAB E-File is restricted to the appeals for which he or she is a party or authorized representative.

Once registered, you may file your appeal by logging in and:

- Clicking the File New Appeal link on the Manage Existing Appeals screen, and then clicking Civil Remedies Division on the File New Appeal screen; and*
- Entering and uploading the requested information and documents on the “File New Appeal – Civil Remedies Division” form.*

All documents must be submitted in PDF form.

What you must include in a hearing request for ALJ review

At minimum, the Civil Remedies Division (CRD) requires a party to file the

following:

- A signed request for hearing that:
 - Identifies the specific issues and the findings of fact and conclusions of law with which the party disagrees; and
 - Specifies the basis for contending that the findings and conclusions are incorrect;
- The underlying notice letter from CMS that sets forth the action taken and the party's appeal rights.

In addition, the following identifying information is required with all ALJ hearing requests:

- Your legal business name
- Your Medicare PTAN (if applicable)
- Tax Identification Number (TIN) or Employer Identification Number (EIN)
- A copy of the Hearing Officer or the CMS Regional Office (RO) decision

The procedures for ALJ review can be found at Title 42 of the Code of Federal Regulations, sections 498.40 – 498.79.

Guidelines for Using DAB E-file

- Any document, including a request for hearing, will be deemed to have been filed on a given day if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day.
- A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the ALJ, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service.
- Parties are responsible for ensuring that DAB E-file email notifications do not go to their spam folders and that any spam filtering software they may have does not restrict their ability to receive emails from the system.
- More detailed instructions on DAB E-File for CRD cases can be found by clicking the CRD E-File Procedures link on the File New Appeal Screen for CRD appeals.

If you are unable to use DAB E-file

Parties are required to use DAB E-file unless they receive a waiver. If you cannot file your appeal electronically, you may mail your hearing request, along with a request for waiver of the electronic filing requirement and an explanation of why you cannot use DAB E-file, to: Department of Health and Human Services, Departmental Appeals Board, Civil Remedies Division, Mail Stop 6132, Attn: CMS Enrollment Appeal, 330 Independence Avenue, S.W., Cohen Building, Room G-644, Washington, D.C. 20201.

Appeal rights can be found 42 C.F.R. part 498. The regulation explains the appeal rights following the determination by the CMS as to whether such

entities meet the requirements for enrollment in the Medicare program.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address]
[Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]

[Position of Hearing Officer]

[MAC Name]

J. Favorable Reconsideration Request Model Letter in Response to a Reactivation Effective Date Determination

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [Day], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of Reconsideration Request]

[Address] (Address from which the Reconsideration Request was sent)

[City], [State] [Zip Code]

Re: Reconsideration Request Decision

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

NPI: [XXXXXXXXXX]

PTAN: [XXXXX]

Reference Number: [XXXX] (optional)

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

This letter is in response to the reconsideration request received by [MAC Name] related to a reactivation effective date determination. The initial determination letter was dated [Month] [DD], [YYYY] and the reconsideration request was received by [MAC Name] on [Month] [DD], [YYYY]; therefore, this reconsideration request is considered timely. (if the reconsideration request is untimely, but good cause has been found to accept the reconsideration request, use the following [This reconsideration request was not timely submitted, but a good cause waiver has been granted.]) The following decision is based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

EFFECTIVE DATE REGULATION(S):

42 C.F.R. § 424.520(a-d) (Other effective date regulations may be included)

OTHER APPLICABLE AUTHORITIES:

42 C.F.R. § 424.540 (Other applicable regulations for MPIM sections may be included)

(Ex: Medicare Program Integrity Manual (MPIM) chapter 10, section 10.XX)

EXHIBITS:

Exhibit 1: (Ex.: CMS-855I Medicare enrollment application, signed and certified by John Smith on [Month] [DD], [YYYY].)

Exhibit 2: (Ex: Copy of an email chain between John Smith and Jane Doe, dated [Month] [DD], [YYYY], requesting additional informed needed to process the revalidation application to completion for John Smith to Jane Doe.

(In this section list each document submitted by the provider or supplier. Each exhibit shall include the date, if provided, as well as a brief description of the document. You shall also include all other documentation not submitted by the provider that the hearing officer reviewed in making the decision, e.g., enrollment applications, development letters, etc.)

BACKGROUND:

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

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

RECONSIDERATION ANALYSIS:

(A reconsideration request reviews whether or not an error was made at the time the initial determination was implemented. This section should summarize the statements made by the provider or supplier in its reconsideration request. Then conduct analysis of the arguments based on the applicable regulations and sub-regulations, MPIM. This section shall not reference a reconsideration decision without explaining how and why you came to that decision.)

DECISION:

(A short conclusory restatement.)

(Ex.: On [Month] [DD], [YYYY], John Smith's revalidation application was approved with a gap in his billing privileges from [Month] [DD], [YYYY] to [Month] [DD], [YYYY]. However, as indicated above, [MAC Name] has determined that the reactivation effective should be [Month] [DD], [YYYY]. As a result of the change in the reactivation effective date, the gap in John Smith's Medicare billing privileges has been eliminated.)

*This decision is a **FAVORABLE DECISION**. To effectuate this decision, [MAC name] [will modify/has modified] the reactivation effective date for [Provider/Supplier Name].*

You must resubmit any claims that were denied or not previously submitted due to the former gap in your Medicare billing privileges.

(If additional information is needed from the provider or supplier in order to

reactivate the enrollment, the MAC shall state what information is needed from the provider or supplier in this reconsideration decision. MACs shall state that the requested information/documentation must be received within 30 calendar days of the date of this decision letter.)

FURTHER APPEAL RIGHTS - ADMINISTRATIVE LAW JUDGE (ALJ):

If you are satisfied with this decision, you do not need to take further action. If you believe that this determination is not correct, you may request ALJ review for the reconsideration portion of this decision letter. To request ALJ review, you must file your appeal with the Civil Remedies Division of the Departmental Appeals Board within 60 calendar days after the date of receipt of this decision.

How to file a hearing request

You can file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at <https://dab.efile.hhs.gov/>.

To file a new appeal using DAB E-File, you first need to register a new account by:

- 1. Clicking Register on the DAB E-File home page;*
- 2. Entering the information requested on the “Register New Account” form; and*
- 3. Clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.*

The e-mail address and password provided during registration must be entered on the login screen at https://dab.efile.hhs.gov/user_sessions/new to access DAB E-File. A registered user’s access to DAB E-File is restricted to the appeals for which he or she is a party or authorized representative.

Once registered, you may file your appeal by logging in and:

- Clicking the File New Appeal link on the Manage Existing Appeals screen, and then clicking Civil Remedies Division on the File New Appeal screen; and*
- Entering and uploading the requested information and documents on the “File New Appeal – Civil Remedies Division” form.*

All documents must be submitted in PDF form.

What you must include in a hearing request for ALJ review

At minimum, the Civil Remedies Division (CRD) requires a party to file the following:

- A signed request for hearing that:*
 - Identifies the specific issues and the findings of fact and conclusions of law with which the party disagrees; and*
 - Specifies the basis for contending that the findings and conclusions are incorrect;*
- The underlying notice letter from CMS that sets forth the action taken*

and the party's appeal rights.

In addition, the following identifying information is required with all ALJ hearing requests:

- *Your legal business name*
- *Your Medicare PTAN (if applicable)*
- *Tax Identification Number (TIN) or Employer Identification Number (EIN)*
- *A copy of the Hearing Officer or the CMS Regional Office (RO) decision*

The procedures for ALJ review can be found at Title 42 of the Code of Federal Regulations, sections 498.40 – 498.79.

Guidelines for Using DAB E-file

- *Any document, including a request for hearing, will be deemed to have been filed on a given day if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day.*
- *A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the ALJ, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service.*
- *Parties are responsible for ensuring that DAB E-file email notifications do not go to their spam folders and that any spam filtering software they may have does not restrict their ability to receive emails from the system.*
- *More detailed instructions on DAB E-File for CRD cases can be found by clicking the CRD E-File Procedures link on the File New Appeal Screen for CRD appeals.*

If you are unable to use DAB E-file

Parties are required to use DAB E-file unless they receive a waiver. If you cannot file your appeal electronically, you may mail your hearing request, along with a request for waiver of the electronic filing requirement and an explanation of why you cannot use DAB E-file, to: Department of Health and Human Services, Departmental Appeals Board, Civil Remedies Division, Mail Stop 6132, Attn: CMS Enrollment Appeal, 330 Independence Avenue, S.W., Cohen Building, Room G-644, Washington, D.C. 20201.

Appeal rights can be found 42 C.F.R. part 498. The regulation explains the appeal rights following the determination by the CMS as to whether such entities meet the requirements for enrollment in the Medicare program.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

*[MAC Appeal Receipt Address]
[Call Center Telephone Number]*

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]

[Position of Hearing Officer]

[MAC Name]

K. Favorable Reconsideration Request Model Letter in Response to an Effective Date of Participation Determination (Non-Revalidation)

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [Day], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of Reconsideration Request]

[Address] (Address from which the Reconsideration Request was sent)

[City], [State] [Zip Code]

Re: Reconsideration Request Decision

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

NPI: [XXXXXXXXXX]

PTAN: [XXXXX]

Reference Number: [XXXX] (optional)

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

This letter is in response to the reconsideration request received by [MAC Name] in response to a determination of the effective date of participation in the Medicare program. The initial determination letter was dated [Month] [DD], [YYYY] and the reconsideration request was received by [MAC Name] on [Month] [DD], [YYYY]; therefore, this reconsideration request is considered timely. (if the reconsideration request is untimely, but good cause has been found to accept the reconsideration request, use the following [This reconsideration request was not timely submitted, but a good cause waiver has been granted.] The following decision is based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

EFFECTIVE DATE REGULATION(S):

42 C.F.R. § 424.520(a-d)

OTHER APPLICABLE AUTHORITIES:

42 C.F.R. §

(Ex: Medicare Program Integrity Manual (MPIM) chapter 10, section 10.XX)

EXHIBITS:

Exhibit 1: (Ex.: CMS-855I Medicare enrollment application, signed and certified by John Smith on [Month] [DD], [YYYY].)

Exhibit 2: (Ex: Copy of an email chain between John Smith and Jane Doe, dated [Month] [DD], [YYYY], submitting the requested development documentation for John Smith to Jane Doe.

(In this section list each document submitted by the provider or supplier. Each exhibit should include the date, as well as a brief description of the document. You shall also include all other documentation not submitted by the provider that the hearing officer reviewed in making the decision, e.g., enrollment applications, development letters, etc.)

BACKGROUND:

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

(Summarize the facts underlying the case which led up to the determination of the effective date.)

RECONSIDERATION ANALYSIS:

(A reconsideration request reviews whether or not an error was made at the time the initial determination was implemented. This section should summarize the statements made by the provider or supplier in its reconsideration request. Then conduct analysis of the arguments based on the applicable regulations and sub-regulations, MPIM. This section shall not reference a reconsideration decision without explaining how and why you came to that decision.)

DECISION:

(A short conclusory restatement.)

(On [Month] [DD], [YYYY], John Smith submitted an initial enrollment application, which was subsequently rejected for failure to timely respond to a development request for additional information/documentation. As part of his reconsideration request, John Smith submitted an email receipt showing that he timely responded to the development request. As a result, [MAC Name] will modify John Smith's Medicare effective date to [Month] [DD], [YYYY].)

*This decision is a **FAVORABLE DECISION**. To effectuate this decision, [MAC name] [will modify/has modified] the enrollment effective date to [Month] [DD], [YYYY].*

(If additional information is needed from the provider or supplier in order to reactivate the enrollment, the MAC shall state what information is needed from the provider or supplier in this reconsideration decision. MACs shall state that the requested information/documentation must be received within 30 calendar days of the date of this decision letter.)

FURTHER APPEAL RIGHTS - ADMINISTRATIVE LAW JUDGE (ALJ):

If you are satisfied with this decision, you do not need to take further action. If you believe that this determination is not correct, you may request ALJ review for the reconsideration portion of this decision letter. To request ALJ review, you must file your appeal with the Civil Remedies Division of the Departmental

Appeals Board within 60 calendar days after the date of receipt of this decision.

How to file a hearing request

You can file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at <https://dab.efile.hhs.gov/>.

To file a new appeal using DAB E-File, you first need to register a new account by:

- 1. Clicking Register on the DAB E-File home page;*
- 2. Entering the information requested on the “Register New Account” form; and*
- 3. Clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.*

The e-mail address and password provided during registration must be entered on the login screen at https://dab.efile.hhs.gov/user_sessions/new to access DAB E-File. A registered user’s access to DAB E-File is restricted to the appeals for which he or she is a party or authorized representative.

Once registered, you may file your appeal by logging in and:

- Clicking the File New Appeal link on the Manage Existing Appeals screen, and then clicking Civil Remedies Division on the File New Appeal screen; and*
- Entering and uploading the requested information and documents on the “File New Appeal – Civil Remedies Division” form.*

All documents must be submitted in PDF form.

What you must include in a hearing request for ALJ review

At minimum, the Civil Remedies Division (CRD) requires a party to file the following:

- A signed request for hearing that:*
 - Identifies the specific issues and the findings of fact and conclusions of law with which the party disagrees; and*
 - Specifies the basis for contending that the findings and conclusions are incorrect;*
- The underlying notice letter from CMS that sets forth the action taken and the party’s appeal rights.*

In addition, the following identifying information is required with all ALJ hearing requests:

- Your legal business name*
- Your Medicare PTAN (if applicable)*
- Tax Identification Number (TIN) or Employer Identification Number (EIN)*
- A copy of the Hearing Officer or the CMS Regional Office (RO) decision*

The procedures for ALJ review can be found at Title 42 of the Code of Federal Regulations, sections 498.40 – 498.79.

Guidelines for Using DAB E-file

- *Any document, including a request for hearing, will be deemed to have been filed on a given day if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day.*
- *A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the ALJ, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service.*
- *Parties are responsible for ensuring that DAB E-file email notifications do not go to their spam folders and that any spam filtering software they may have does not restrict their ability to receive emails from the system.*
- *More detailed instructions on DAB E-File for CRD cases can be found by clicking the CRD E-File Procedures link on the File New Appeal Screen for CRD appeals.*

If you are unable to use DAB E-file

Parties are required to use DAB E-file unless they receive a waiver. If you cannot file your appeal electronically, you may mail your hearing request, along with a request for waiver of the electronic filing requirement and an explanation of why you cannot use DAB E-file, to: Department of Health and Human Services, Departmental Appeals Board, Civil Remedies Division, Mail Stop 6132, Attn: CMS Enrollment Appeal, 330 Independence Avenue, S.W., Cohen Building, Room G-644, Washington, D.C. 20201.

Appeal rights can be found 42 C.F.R. part 498. The regulation explains the appeal rights following the determination by the CMS as to whether such entities meet the requirements for enrollment in the Medicare program.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

*[MAC Appeal Receipt Address]
[Call Center Telephone Number]
Sincerely,*

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

L. Favorable Reconsideration Request Model Letter for Revocation Determination

(To be sent by hard-copy mail and email if email address is provided. Optional

to send via fax if a valid fax number is available).

[Month] [Day], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of Reconsideration Request]

[Address] (Address from which the Reconsideration Request was sent)

[City], [State] [Zip Code]

Re: Reconsideration Request Decision

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

NPI: [XXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXX] (optional)

Dear [Person(s) who submitted the Reconsideration Request]:

This letter is in response to the reconsideration request received by [MAC Name] based on a revocation of Medicare billing privileges. The initial determination letter was dated [Month] [DD], [YYYY] and the reconsideration request was received by [MAC Name] on [Month] [DD], [YYYY]; therefore, this appeal is considered timely. (if the reconsideration request is untimely, but good cause has been found to accept the reconsideration request, use the following [This reconsideration request was not timely submitted, but a good cause waiver has been granted.]) The following decision is based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

REVOCATION REASON(S):

42 C.F.R. § 424.535(a)(revocation reason 1-22)

42 C.F.R. § 424.535(a)(revocation reason 1-22)

OTHER APPLICABLE AUTHORITIES:

42 C.F.R. §

(Ex: Medicare Program Integrity Manual chapter 10, section 10.XX)

EXHIBITS:

Exhibit 1: (Ex.: Reconsideration request, signed by Jane Doe, dated [Month] [DD] [YYYY].)

Exhibit 2: (Ex: Copy of a medical license for Jane Doe from the Wisconsin Medical Board, effective [Month] [DD], [YYYY].)

(In this section list each document submitted by the provider or supplier. Each exhibit should include the date, as well as a brief description of the document. You shall also include all other documentation not submitted by the provider that the hearing officer reviewed in making the decision, e.g., enrollment applications, development letters, etc.)

BACKGROUND:

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

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

RECONSIDERATION ANALYSIS:

(The hearing officer needs to check to determine if a CAP was also submitted and approved for this provider or supplier. If so, the reconsideration decision should only address the remaining authorities and use the following sentence, “[MAC Name] has reviewed and/or approved the CAP submitted on [Month] [DD], [YYYY] in a decision dated [Month] [DD], [YYYY].

Therefore, this decision will only address the remaining revocation reason(s) 42 C.F.R. § 424.535(a)(revocation reason 1- 22).)

(If the CAP resolves the revocation in its entirety, the applicable moot model letter should be issued in response to the reconsideration request instead of this decision template.)

(A reconsideration request reviews whether or not an error was made at the time the initial determination was implemented. This section should summarize the statements made by the provider or supplier in its reconsideration request. Then conduct analysis of the provider or supplier arguments based on the applicable regulations and sub-regulations (MPIM). This section shall not reference a reconsideration decision without explaining how and why you came to that decision.)

DECISION:

(A short conclusory restatement.)

(Ex: On [Month] [DD], [YYYY], Jane Doe’s medical license was temporarily suspended by the Wisconsin medical board based on allegations of malpractice. However, on [Month] [DD] [YYYY], the Wisconsin medical board issued an order reversing the license suspension back to its implementation date based on the outcome of a hearing. As a result, [MAC Name] is overturning the revocation of Jane Doe’s Medicare billing privileges as it relates to 42 C.F.R. § 424.535(a)(1).

*This decision is a **FAVORABLE DECISION**. To effectuate this decision, [MAC name] [will reinstate/has reinstated] your Medicare billing privileges, effective [Month] [DD], [YYYY].*

(The reinstatement date is based on chapter 10 of the MPIM and the date of the provider’s or supplier’s revocation or the date the provider’s or supplier’s license was reinstated if the revocation involves a licensure issue.)

(If additional information is needed from the provider or supplier in order to reactivate the enrollment, the MAC shall state what information is needed from the provider or supplier in this reconsideration decision. MACs shall state that the requested information/documentation must be received within 30 calendar days of the date of this decision letter.)

FURTHER APPEAL RIGHTS - ADMINISTRATIVE LAW JUDGE (ALJ):

If you are satisfied with this decision, you do not need to take further action. If you believe that this determination is not correct, you may request ALJ review for the reconsideration portion of this decision letter. To request ALJ review, you must file your appeal with the Civil Remedies Division of the Departmental Appeals Board within 60 calendar days after the date of receipt of this decision.

How to file a hearing request

You can file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at <https://dab.efile.hhs.gov/>.

To file a new appeal using DAB E-File, you first need to register a new account by:

1. Clicking Register on the DAB E-File home page;
2. Entering the information requested on the “Register New Account” form; and
3. Clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.

The e-mail address and password provided during registration must be entered on the login screen at https://dab.efile.hhs.gov/user_sessions/new to access DAB E-File. A registered user’s access to DAB E-File is restricted to the appeals for which he or she is a party or authorized representative.

Once registered, you may file your appeal by logging in and:

- Clicking the File New Appeal link on the Manage Existing Appeals screen, and then clicking Civil Remedies Division on the File New Appeal screen; and
- Entering and uploading the requested information and documents on the “File New Appeal – Civil Remedies Division” form.

All documents must be submitted in PDF form.

What you must include in a hearing request for ALJ review

At minimum, the Civil Remedies Division (CRD) requires a party to file the following:

- A signed request for hearing that:
 - Identifies the specific issues and the findings of fact and conclusions of law with which the party disagrees; and
 - Specifies the basis for contending that the findings and conclusions are incorrect;
- The underlying notice letter from CMS that sets forth the action taken and the party’s appeal rights.

In addition, the following identifying information is required with all ALJ hearing requests:

- Your legal business name
- Your Medicare PTAN (if applicable)

- *Tax Identification Number (TIN) or Employer Identification Number (EIN)*
- *A copy of the Hearing Officer or the CMS Regional Office (RO) decision*

The procedures for ALJ review can be found at Title 42 of the Code of Federal Regulations, sections 498.40 – 498.79.

Guidelines for Using DAB E-file

- *Any document, including a request for hearing, will be deemed to have been filed on a given day if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day.*
- *A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the ALJ, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service.*
- *Parties are responsible for ensuring that DAB E-file email notifications do not go to their spam folders and that any spam filtering software they may have does not restrict their ability to receive emails from the system.*
- *More detailed instructions on DAB E-File for CRD cases can be found by clicking the CRD E-File Procedures link on the File New Appeal Screen for CRD appeals.*

If you are unable to use DAB E-file

Parties are required to use DAB E-file unless they receive a waiver. If you cannot file your appeal electronically, you may mail your hearing request, along with a request for waiver of the electronic filing requirement and an explanation of why you cannot use DAB E-file, to: Department of Health and Human Services, Departmental Appeals Board, Civil Remedies Division, Mail Stop 6132, Attn: CMS Enrollment Appeal, 330 Independence Avenue, S.W., Cohen Building, Room G-644, Washington, D.C. 20201.

Appeal rights can be found 42 C.F.R. part 498. The regulation explains the appeal rights following the determination by the CMS as to whether such entities meet the requirements for enrollment in the Medicare program.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

*[MAC Appeal Receipt Address]
[Call Center Telephone Number]*

Sincerely,

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

[MAC Name]

M. Unfavorable Reconsideration Request Model Letter in Response to an Enrollment Denial

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [Day], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of Reconsideration Request]

[Address] (Address from which the Reconsideration Request was sent)

[City], [State] [Zip Code]

Re: Reconsideration Request Decision

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

NPI: [XXXXXXXXXX]

PTAN: [XXXXX]

Reference Number: [XXXX] (optional)

Dear [Person(s) who submitted the Reconsideration Request]:

This letter is in response to the reconsideration request received by [MAC Name] based on an enrollment denial. The initial determination letter was dated [Month] [DD], [YYYY] and the reconsideration request was received by [MAC Name] on [Month] [DD], [YYYY]; therefore, this appeal is considered timely. (if the reconsideration request is untimely, but good cause has been found to accept the reconsideration request, use the following [This reconsideration request was not timely submitted, but a good cause waiver has been granted.]) The following decision is based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

DENIAL REASON(S):

42 C.F.R. § 424.530(a)(denial reason 1-14)

42 C.F.R. § 424.530(a)(denial reason 1-14)

OTHER APPLICABLE AUTHORITIES:

42 C.F.R. §

(Ex: Medicare Program Integrity Manual chapter 10, section 10.XX)

EXHIBITS:

Exhibit 1: (Ex.: Reconsideration request, signed by Jane Doe, dated [Month] [DD] [YYYY].)

Exhibit 2: (Ex: Copy of a medical license for Jane Doe from the Wisconsin Medical Board, effective [Month] [DD], [YYYY].)

(In this section list each document submitted by the provider or supplier. Each exhibit should include the date, as well as a brief description of the document. You shall also include all other documentation not submitted by the provider that the hearing officer reviewed in making the decision, e.g., enrollment

(applications, development letters, etc.)

BACKGROUND:

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

[Summarize the facts underlying the case which led up to the submission of the reconsideration request.]

RECONSIDERATION ANALYSIS:

(The hearing officer needs to check to determine if a CAP was also submitted and approved for this provider or supplier. If so, the reconsideration decision should only address the remaining authorities and use the following sentence, “[MAC Name] has approved the CAP submitted on [Month] [DD], [YYYY] in a decision dated [Month] [DD], [YYYY]. Therefore, this decision will only address the remaining denial reason(s) 42 C.F.R. § 424.530(a)(denial reason 1-14).)

(If the CAP resolves the denial in its entirety, the applicable moot model letter should be issued in response to the reconsideration request instead of this decision template.)

(A reconsideration request reviews whether or not an error was made at the time the initial determination was implemented. This section should summarize the statements made by the provider or supplier in its reconsideration request. Then conduct analysis of the arguments based on the applicable regulations and sub-regulations (MPIM). This section shall not reference a reconsideration decision without explaining how and why you came to that decision.)

DECISION:

(A short conclusory restatement.)

(Ex: On [Month] [DD], [YYYY], Jane Doe’s medical license was temporarily suspended by the Wisconsin medical board based on allegations of malpractice. Jane Doe did not submit any documentation to demonstrate that her medical license was not suspended. In addition, [MAC Name] has confirmed that Jane Doe’s medical license remains suspended. As a result, [MAC Name] upholds the denial of Jane Doe’s Medicare enrollment application as it relates to 42 C.F.R. § 424.530(a)(1).)

*This decision is an **UNFAVORABLE DECISION**. [MAC name] concludes that there was no error made in the denial of your Medicare enrollment. As a result, the denial of your Medicare enrollment is upheld.*

FURTHER APPEAL RIGHTS - ADMINISTRATIVE LAW JUDGE (ALJ):

If you are satisfied with this decision, you do not need to take further action. If you believe that this determination is not correct, you may request ALJ review for the reconsideration portion of this decision letter. To request ALJ review, you must file your appeal with the Civil Remedies Division of the Departmental Appeals Board within 60 calendar days after the date of receipt of this

decision.

How to file a hearing request

You can file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at <https://dab.efile.hhs.gov/>.

To file a new appeal using DAB E-File, you first need to register a new account by:

- 1. Clicking Register on the DAB E-File home page;*
- 2. Entering the information requested on the “Register New Account” form; and*
- 3. Clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.*

The e-mail address and password provided during registration must be entered on the login screen at https://dab.efile.hhs.gov/user_sessions/new to access DAB E-File. A registered user’s access to DAB E-File is restricted to the appeals for which he or she is a party or authorized representative.

Once registered, you may file your appeal by logging in and:

- Clicking the File New Appeal link on the Manage Existing Appeals screen, and then clicking Civil Remedies Division on the File New Appeal screen; and*
- Entering and uploading the requested information and documents on the “File New Appeal – Civil Remedies Division” form.*

All documents must be submitted in PDF form.

What you must include in a hearing request for ALJ review

At minimum, the Civil Remedies Division (CRD) requires a party to file the following:

- A signed request for hearing that:*
 - Identifies the specific issues and the findings of fact and conclusions of law with which the party disagrees; and*
 - Specifies the basis for contending that the findings and conclusions are incorrect;*
- The underlying notice letter from CMS that sets forth the action taken and the party’s appeal rights.*

In addition, the following identifying information is required with all ALJ hearing requests:

- Your legal business name*
- Your Medicare PTAN (if applicable)*
- Tax Identification Number (TIN) or Employer Identification Number (EIN)*
- A copy of the Hearing Officer or the CMS Regional Office (RO)*

decision

The procedures for ALJ review can be found at Title 42 of the Code of Federal Regulations, sections 498.40 – 498.79.

Guidelines for Using DAB E-file

- *Any document, including a request for hearing, will be deemed to have been filed on a given day if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day.*
- *A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the ALJ, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service.*
- *Parties are responsible for ensuring that DAB E-file email notifications do not go to their spam folders and that any spam filtering software they may have does not restrict their ability to receive emails from the system.*
- *More detailed instructions on DAB E-File for CRD cases can be found by clicking the CRD E-File Procedures link on the File New Appeal Screen for CRD appeals.*

If you are unable to use DAB E-file

Parties are required to use DAB E-file unless they receive a waiver. If you cannot file your appeal electronically, you may mail your hearing request, along with a request for waiver of the electronic filing requirement and an explanation of why you cannot use DAB E-file, to: Department of Health and Human Services, Departmental Appeals Board, Civil Remedies Division, Mail Stop 6132, Attn: CMS Enrollment Appeal, 330 Independence Avenue, S.W., Cohen Building, Room G-644, Washington, D.C. 20201.

Appeal rights can be found 42 C.F.R. part 498. The regulation explains the appeal rights following the determination by the CMS as to whether such entities meet the requirements for enrollment in the Medicare program.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

*[MAC Appeal Receipt Address]
[Call Center Telephone Number]*

Sincerely,

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

N. Unfavorable Reconsideration Request Model Letter in Response to a Reactivation Effective Date Determination

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [Day], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of Reconsideration Request]

[Address] (Address from which the Reconsideration Request was sent)

[City], [State] [Zip Code]

Re: Reconsideration Request Decision

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

NPI: [XXXXXXXXXX]

PTAN: [XXXXX]

Reference Number: [XXXX] (optional)

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

This letter is in response to the reconsideration request received by [MAC Name] in response to a reactivation effective date determination. The initial determination letter was dated [Month] [DD], [YYYY] and the reconsideration request was received by [MAC Name] on [Month] [DD], [YYYY]; therefore, this appeal is considered timely. (if the reconsideration request is untimely, but good cause has been found to accept the reconsideration request, use the following [This reconsideration request was not timely submitted, but a good cause waiver has been granted.]) The following decision is based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

EFFECTIVE DATE REGULATION(S):

42 C.F.R. § 424.520(a-d) (Other effective date regulations may be included)

OTHER APPLICABLE AUTHORITIES:

42 C.F.R. § 424.540 (Other applicable regulations for MPIM sections may be included)

(Ex: Medicare Program Integrity Manual (MPIM) chapter 10, section 10.XX)

EXHIBITS:

Exhibit 1: (Ex.: CMS-855I Medicare enrollment application, signed and certified by John Smith on [Month] [DD], [YYYY].)

Exhibit 2: (Ex: Copy of an email chain between John Smith and Jane Doe, dated [Month] [DD], [YYYY], submitting the requested development documentation for John Smith to Jane Doe.)

(In this section list each document submitted by the provider or supplier. Each exhibit should include the date, as well as a brief description of the document. You shall also include all other documentation not submitted by the provider that the hearing officer reviewed in making the decision, e.g., enrollment applications, development letters, etc.)

BACKGROUND:

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

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

RECONSIDERATION ANALYSIS:

(A reconsideration request reviews whether or not an error was made at the time the initial determination was implemented. This section should summarize the statements made by the provider or supplier in its reconsideration request. Then conduct analysis of the arguments based on the applicable regulations and sub-regulations, MPIM. This section shall not reference a reconsideration decision without explaining how and why you came to that decision.)

DECISION:

(A short conclusory restatement.)

(On [Month] [DD], [YYYY], John Smith's Medicare enrollment was deactivated for failing to timely respond to a revalidation request. On [Month] [DD], [YYYY], John Smith submitted a revalidation application, which was processed and approved. Per the MPIM, Ch. 10, Section 10.4(K), John Smith's Medicare enrollment was reactivated, but with a gap in his Medicare billing privileges from [Month] [DD], [YYYY] to [Month] [DD], [YYYY]. John Smith's reconsideration request did not demonstrate an error in the determination of his reactivation effective date.)

*This decision is an **UNFAVORABLE DECISION**. [MAC name] concludes that no error was made in the determination of a reactivation effective date resulting in a gap in your Medicare billing privileges. As a result, your reactivation effective date will remain [Month] [DD] [YYYY].*

FURTHER APPEAL RIGHTS - ADMINISTRATIVE LAW JUDGE (ALJ):

If you are satisfied with this decision, you do not need to take further action. If you believe that this determination is not correct, you may request ALJ review for the reconsideration portion of this decision letter. To request ALJ review, you must file your appeal with the Civil Remedies Division of the Departmental Appeals Board within 60 calendar days after the date of receipt of this decision.

How to file a hearing request

You can file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at <https://dab.efile.hhs.gov/>.

To file a new appeal using DAB E-File, you first need to register a new account by:

- 1. Clicking Register on the DAB E-File home page;*
- 2. Entering the information requested on the "Register New Account" form; and*

3. Clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.

The e-mail address and password provided during registration must be entered on the login screen at https://dab.efile.hhs.gov/user_sessions/new to access DAB E-File. A registered user's access to DAB E-File is restricted to the appeals for which he or she is a party or authorized representative.

Once registered, you may file your appeal by logging in and:

- *Clicking the File New Appeal link on the Manage Existing Appeals screen, and then clicking Civil Remedies Division on the File New Appeal screen; and*
- *Entering and uploading the requested information and documents on the “File New Appeal – Civil Remedies Division” form.*

All documents must be submitted in PDF form.

What you must include in a hearing request for ALJ review

At minimum, the Civil Remedies Division (CRD) requires a party to file the following:

- *A signed request for hearing that:*
 - *Identifies the specific issues and the findings of fact and conclusions of law with which the party disagrees; and*
 - *Specifies the basis for contending that the findings and conclusions are incorrect;*
- *The underlying notice letter from CMS that sets forth the action taken and the party's appeal rights.*

In addition, the following identifying information is required with all ALJ hearing requests:

- *Your legal business name*
- *Your Medicare PTAN (if applicable)*
- *Tax Identification Number (TIN) or Employer Identification Number (EIN)*
- *A copy of the Hearing Officer or the CMS Regional Office (RO) decision*

The procedures for ALJ review can be found at Title 42 of the Code of Federal Regulations, sections 498.40 – 498.79.

Guidelines for Using DAB E-file

- *Any document, including a request for hearing, will be deemed to have been filed on a given day if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day.*
- *A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the ALJ, via DAB E-File. Correspondingly, CMS will also be deemed to have consented*

to electronic service.

- *Parties are responsible for ensuring that DAB E-file email notifications do not go to their spam folders and that any spam filtering software they may have does not restrict their ability to receive emails from the system.*
- *More detailed instructions on DAB E-File for CRD cases can be found by clicking the CRD E- File Procedures link on the File New Appeal Screen for CRD appeals.*

If you are unable to use DAB E-file

Parties are required to use DAB E-file unless they receive a waiver. If you cannot file your appeal electronically, you may mail your hearing request, along with a request for waiver of the electronic filing requirement and an explanation of why you cannot use DAB E-file, to: Department of Health and Human Services, Departmental Appeals Board, Civil Remedies Division, Mail Stop 6132, Attn: CMS Enrollment Appeal, 330 Independence Avenue, S.W., Cohen Building, Room G-644, Washington, D.C. 20201.

Appeal rights can be found 42 C.F.R. part 498. The regulation explains the appeal rights following the determination by the CMS as to whether such entities meet the requirements for enrollment in the Medicare program.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

*[MAC Appeal Receipt Address]
[Call Center Telephone Number]*

Sincerely,

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

O. Unfavorable Reconsideration Request Model Letter in Response to an Effective Date of Participation Determination (Non-Revalidation)

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [Day], [YYYY]

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

*Re: Reconsideration Request Decision
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXXXX]*

PTAN: [XXXXX]

Reference Number: [XXXX] (optional)

Dear [Person(s) who submitted the Reconsideration Request]:

This letter is in response to the reconsideration request received by [MAC Name] based on an effective date of enrollment determination. The initial determination letter was dated [Month] [DD], [YYYY] and the reconsideration request was received by [MAC Name] on [Month] [DD], [YYYY]; therefore, this appeal is considered timely. (if the reconsideration request is untimely, but good cause has been found to accept the reconsideration request, use the following [This reconsideration request was not timely submitted, but a good cause waiver has been granted.]) The following decision is based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

EFFECTIVE DATE REGULATION(S):

42 C.F.R. § 424.520(a-d)

OTHER APPLICABLE AUTHORITIES:

42 C.F.R. §

(Ex: Medicare Program Integrity Manual chapter 10, section 10.XX)

EXHIBITS:

Exhibit 1: (Ex.: CMS-855I Medicare enrollment application, signed and certified by John Smith on [Month] [DD], [YYYY].)

Exhibit 2: (Ex: Copy of an email chain between John Smith and Jane Doe, dated [Month] [DD], [YYYY], submitting the requested development documentation for John Smith to Jane Doe.)

(In this section list each document submitted by the provider or supplier. Each exhibit should include the date, as well as a brief description of the document. You shall also include all other documentation not submitted by the provider that the hearing officer reviewed in making the decision, e.g., enrollment applications, development letters, etc.)

BACKGROUND:

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

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

RECONSIDERATION ANALYSIS:

(A reconsideration request reviews whether or not an error was made at the time the initial determination was implemented. This section should summarize the statements made by the provider or supplier in its reconsideration request. Then conduct analysis of the arguments based on the applicable regulations

and sub-regulations (MPIM). This section shall not reference a reconsideration decision without explaining how and why you came to that decision.)

DECISION:

(A short conclusory restatement.)

(On [Month] [DD], [YYYY], John Smith submitted an initial Medicare enrollment application. On [Month] [DD], [YYYY], [MAC Name] sent a development request to John Smith for additional documentation/information to continue processing his enrollment application.

However, John Smith did not submit the requested documentation within 30 days. As a result, [MAC Name] properly rejected John Smith's Medicare enrollment application received on [Month] [DD] [YYYY]. On [Month] [DD] [YYYY], John Smith submitted another Medicare enrollment application, which was processed and subsequently approved with an effective date of [Month] [DD], [YYYY] in accordance with 42 C.F.R. § 424.520.

*This decision is an **UNFAVORABLE DECISION**. [MAC name] concludes that no error was made in the determination of your effective date of participation in the Medicare program. As a result, the effective date of participation will remain the same.*

FURTHER APPEAL RIGHTS - ADMINISTRATIVE LAW JUDGE (ALJ):

If you are satisfied with this decision, you do not need to take further action. If you believe that this determination is not correct, you may request ALJ review for the reconsideration portion of this decision letter. To request ALJ review, you must file your appeal with the Civil Remedies Division of the Departmental Appeals Board within 60 calendar days after the date of receipt of this decision.

How to file a hearing request

You can file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at <https://dab.efile.hhs.gov/>.

To file a new appeal using DAB E-File, you first need to register a new account by:

- 1. Clicking Register on the DAB E-File home page;*
- 2. Entering the information requested on the "Register New Account" form; and*
- 3. Clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.*

The e-mail address and password provided during registration must be entered on the login screen at https://dab.efile.hhs.gov/user_sessions/new to access DAB E-File. A registered user's access to DAB E-File is restricted to the appeals for which he or she is a party or authorized representative.

Once registered, you may file your appeal by logging in and:

- Clicking the *File New Appeal* link on the *Manage Existing Appeals* screen, and then clicking *Civil Remedies Division* on the *File New Appeal* screen; and
- Entering and uploading the requested information and documents on the “*File New Appeal – Civil Remedies Division*” form.

All documents must be submitted in PDF form.

What you must include in a hearing request for ALJ review

At minimum, the Civil Remedies Division (CRD) requires a party to file the following:

- *A signed request for hearing that:*
 - *Identifies the specific issues and the findings of fact and conclusions of law with which the party disagrees; and*
 - *Specifies the basis for contending that the findings and conclusions are incorrect;*
- *The underlying notice letter from CMS that sets forth the action taken and the party’s appeal rights.*

In addition, the following identifying information is required with all ALJ hearing requests:

- *Your legal business name*
- *Your Medicare PTAN (if applicable)*
- *Tax Identification Number (TIN) or Employer Identification Number (EIN)*
- *A copy of the Hearing Officer or the CMS Regional Office (RO) decision*

The procedures for ALJ review can be found at Title 42 of the Code of Federal Regulations, sections 498.40 – 498.79.

Guidelines for Using DAB E-file

- *Any document, including a request for hearing, will be deemed to have been filed on a given day if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day.*
- *A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the ALJ, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service.*
- *Parties are responsible for ensuring that DAB E-file email notifications do not go to their spam folders and that any spam filtering software they may have does not restrict their ability to receive emails from the system.*
- *More detailed instructions on DAB E-File for CRD cases can be found by clicking the CRD E- File Procedures link on the File New Appeal Screen for CRD appeals.*

If you are unable to use DAB E-file

Parties are required to use DAB E-file unless they receive a waiver. If you cannot file your appeal electronically, you may mail your hearing request, along with a request for waiver of the electronic filing requirement and an explanation of why you cannot use DAB E-file, to: Department of Health and Human Services, Departmental Appeals Board, Civil Remedies Division, Mail Stop 6132, Attn: CMS Enrollment Appeal, 330 Independence Avenue, S.W., Cohen Building, Room G-644, Washington, D.C. 20201.

Appeal rights can be found 42 C.F.R. part 498. The regulation explains the appeal rights following the determination by the CMS as to whether such entities meet the requirements for enrollment in the Medicare program.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

*[MAC Appeal Receipt Address]
[Call Center Telephone Number]*

Sincerely,

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

P. Unfavorable Reconsideration Request Model Letter for Revocation Determination

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [Day], [YYYY]

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

*Re: Reconsideration Request Decision
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)*

Dear [Person(s) who submitted the Reconsideration Request]:

This letter is in response to the reconsideration request received by [MAC Name] based on a revocation of Medicare billing privileges. The initial determination letter was dated [Month] [DD], [YYYY] and the reconsideration request was received by [MAC Name] on [Month] [DD], [YYYY]; therefore, this appeal is considered timely. (if the reconsideration request is untimely, but good cause has been found to accept the reconsideration request, use the following [This reconsideration request was not timely submitted, but a good cause waiver has been granted.]) The following decision is based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and

any information received before this decision was rendered.

REVOCATION REASON(S):

42 C.F.R. § 424.535(a)(revocation reason 1-22)

42 C.F.R. § 424.535(a)(revocation reason 1-22)

OTHER APPLICABLE AUTHORITIES:

42 C.F.R. §

(Ex: Medicare Program Integrity Manual chapter 10, section 10.XX)

EXHIBITS:

Exhibit 1: (Ex.: Reconsideration request, signed by Jane Doe, dated [Month] [DD] [YYYY].)

Exhibit 2: (Ex: Copy of a medical license for Jane Doe from the Wisconsin Medical Board, effective [Month] [DD], [YYYY].)

(In this section list each document submitted by the provider or supplier. Each exhibit should include the date, as well as a brief description of the document. You shall also include all other documentation not submitted by the provider that the hearing officer reviewed in making the decision, e.g., enrollment applications, development letters, etc.)

BACKGROUND:

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

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

RECONSIDERATION ANALYSIS:

(The hearing officer needs to check to determine if a CAP was also submitted and approved for this provider or supplier. If so, the reconsideration decision should only address the remaining authorities and use the following sentence, “[MAC Name] has denied or approved the CAP submitted on [Month] [DD], [YYYY] in a decision dated [Month] [DD], [YYYY]. Therefore, this decision will only address the remaining revocation reason(s) 42 C.F.R. § 424.535(a)(revocation reason 1-22).)

(If the CAP resolves the revocation in its entirety, the applicable moot model letter should be issued in response to the reconsideration request instead of this decision template.)

(A reconsideration request reviews whether or not an error was made at the time the initial determination was implemented. This section should summarize the statements made by the provider or supplier in its reconsideration request. Then conduct analysis of the arguments based on the applicable regulations and sub-regulations (MPIM). This section shall not reference a reconsideration decision without explaining how and why you came to that decision.)

DECISION:

(A short conclusory restatement.)

(On [Month] [DD], [YYYY], Jane Doe’s medical license was suspended by the Wisconsin

Medical Board. Jane Doe has not submitted evidence to demonstrate that the suspension of her medical license was rescinded. In addition, [MAC Name] has confirmed that Jane Doe's medical license remains suspended. As a result, [MAC Name] upholds the revocation of Jane Doe's Medicare enrollment application under 42 C.F.R. § 424.535(a)(1).)

*This decision is an **UNFAVORABLE DECISION**. [MAC name] concludes that there was no error made in the implementation of a revocation. As a result, the revocation of your Medicare billing privileges is upheld.*

FURTHER APPEAL RIGHTS - ADMINISTRATIVE LAW JUDGE (ALJ):

If you are satisfied with this decision, you do not need to take further action. If you believe that this determination is not correct, you may request ALJ review for the reconsideration portion of this decision letter. To request ALJ review, you must file your appeal with the Civil Remedies Division of the Departmental Appeals Board within 60 calendar days after the date of receipt of this decision.

How to file a hearing request

You can file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at <https://dab.efile.hhs.gov/>.

To file a new appeal using DAB E-File, you first need to register a new account by:

- 1. Clicking Register on the DAB E-File home page;*
- 2. Entering the information requested on the "Register New Account" form; and*
- 3. Clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.*

The e-mail address and password provided during registration must be entered on the login screen at https://dab.efile.hhs.gov/user_sessions/new to access DAB E-File. A registered user's access to DAB E-File is restricted to the appeals for which he or she is a party or authorized representative.

Once registered, you may file your appeal by logging in and:

- Clicking the File New Appeal link on the Manage Existing Appeals screen, and then clicking Civil Remedies Division on the File New Appeal screen; and*
- Entering and uploading the requested information and documents on the "File New Appeal – Civil Remedies Division" form.*

All documents must be submitted in PDF form.

What you must include in a hearing request for ALJ review

At minimum, the Civil Remedies Division (CRD) requires a party to file the following:

- A signed request for hearing that:*

- *Identifies the specific issues and the findings of fact and conclusions of law with which the party disagrees; and*
- *Specifies the basis for contending that the findings and conclusions are incorrect;*
- *The underlying notice letter from CMS that sets forth the action taken and the party's appeal rights.*

In addition, the following identifying information is required with all ALJ hearing requests:

- *Your legal business name*
- *Your Medicare PTAN (if applicable)*
- *Tax Identification Number (TIN) or Employer Identification Number (EIN)*
- *A copy of the Hearing Officer or the CMS Regional Office (RO) decision*

The procedures for ALJ review can be found at Title 42 of the Code of Federal Regulations, sections 498.40 – 498.79.

Guidelines for Using DAB E-file

- *Any document, including a request for hearing, will be deemed to have been filed on a given day if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day.*
- *A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the ALJ, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service.*
- *Parties are responsible for ensuring that DAB E-file email notifications do not go to their spam folders and that any spam filtering software they may have does not restrict their ability to receive emails from the system.*
- *More detailed instructions on DAB E-File for CRD cases can be found by clicking the CRD E-File Procedures link on the File New Appeal Screen for CRD appeals.*

If you are unable to use DAB E-file

Parties are required to use DAB E-file unless they receive a waiver. If you cannot file your appeal electronically, you may mail your hearing request, along with a request for waiver of the electronic filing requirement and an explanation of why you cannot use DAB E-file, to: Department of Health and Human Services, Departmental Appeals Board, Civil Remedies Division, Mail Stop 6132, Attn: CMS Enrollment Appeal, 330 Independence Avenue, S.W., Cohen Building, Room G-644, Washington, D.C. 20201.

Appeal rights can be found 42 C.F.R. part 498. The regulation explains the appeal rights following the determination by the CMS as to whether such entities meet the requirements for enrollment in the Medicare program.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address]
[Call Center Telephone Number]

Sincerely,

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

Q. Reconsideration Further Information Required for Development Model Letter

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

To: [Email address provided by the person who submitted the Reconsideration.]
Subject: Medicare Provider Enrollment Reconsideration re: [Provider/Supplier Name]

[Month] [DD], [YYYY]

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

Re: Reconsideration Decision
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXX]
Reference Number: [XXXX] (Internal Tracking)

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

On [Month] [DD], [YYYY], [MAC Name] issued a reconsideration decision. As stated in the [Month] [DD], [YYYY] reconsideration decision letter, the approval of [Provider/Supplier Name]'s Medicare enrollment is contingent upon the submission of [list required documentation]. Please send the required documentation within 30 calendar days to:

[MAC Reconsideration Receipt Address] [MAC Reconsideration Receipt Email Address]
[MAC Reconsideration Receipt Fax Number]
If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

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

10.7.12 – Deactivation Model Letter

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

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [DD], [YYYY]

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

[Address]

[City], [State] [Zip Code]

Re: Deactivation of Medicare billing privileges

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

NPI: [XXXXXXXXXX]

PTAN: [XXXXX]

Reference Number: [XXXX] (Internal Tracking)

Dear [Provider/Supplier Name]:

Your Medicare billing privileges are being deactivated effective [Month] [DD], [YYYY] pursuant to:

DEACTIVATION REASON:

- *42 C.F.R. § 424.540(a)[1-2]*

[Specific reason for the deactivation of the provider/supplier's Medicare billing privileges.]

(If the deactivation is under 424.540(a)(1), an example narrative may include:

[MAC Name] has reviewed your Medicare billing data and found that you have not submitted any claims since January 1, 2017, which is more than twelve calendar months from the date of this letter.)

(If the deactivation is under 424.540(a)(2), an example narrative may include:

[MAC Name] has been informed that John Smith is deceased as of January 1, 2017. Your Medicare enrollment application, signed and certified on November 1, 2016, identifies John Smith as a 5% or greater owner. [MAC Name] has not received a Medicare enrollment application reporting this change in ownership.)

REBUTTAL RIGHTS:

If you believe that this determination is not correct, you may rebut the deactivation as indicated in 42 C.F.R. § 424.545(b). The rebuttal must be received by this office in writing within 20 calendar days of the date of this letter. The rebuttal must state the issues or findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the rebuttal that you believe may have a bearing on the decision. You must submit all information that you would like to be considered in conjunction with the rebuttal. This includes any application(s) to update your enrollment, if necessary. You may only submit one rebuttal in response to this deactivation of your Medicare enrollment.

The rebuttal must be signed and dated by the individual provider/supplier, the authorized or delegated official, or a legal representative.

If the provider/supplier wishes to appoint a legal representative that is not an attorney to sign the rebuttal, the provider/supplier must include with the rebuttal a written notice authorizing

the legal representative to act on the provider/supplier's behalf. The notice should be signed by the provider/supplier.

If the provider/supplier has an attorney sign the rebuttal, the rebuttal must include a statement from the attorney that he/she has the authority to represent the provider/supplier.

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

The rebuttal should be sent to the following:

[MAC Rebuttal Receipt Address]

[MAC Rebuttal Receipt Email Address]

[MAC Rebuttal Receipt Fax Number]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name] [Title] [Company]

10.7.13 – Rebuttal Model Letters

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

Instruction

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

A. Rebuttal Signature Development Model Letter

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

To: [Email address provided by the person who submitted the rebuttal.]

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

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

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

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

[City], [State] [Zip Code]

Re: Rebuttal Determination

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

NPI: [XXXXXXXXXX]

PTAN: [XXXXX]

Reference Number: [XXXX] (Internal Tracking)

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

We are in receipt of your rebuttal submission, received on [Month] [DD], [YYYY].

(If the submission is not properly signed, use the following.) Your submission is not appropriately signed, as required in the Medicare Program Integrity Manual, Ch. 10, Section 10.4(M). [MAC Name] is requesting that you submit a rebuttal properly signed by the individual provider, supplier, the authorized or delegated official, or a legal representative. Your properly signed submission must be received within 15 calendar days of the date of this notice. If you do not timely respond to this request, your rebuttal submission may be dismissed.

(If the submission is missing a statement by the attorney, use the following.) Your submission is missing an attorney statement that he or she has the authority to represent the provider or supplier. [MAC Name] is requesting that you submit a rebuttal that includes an attorney statement that he or she has the authority to represent the provider or supplier within 15 calendar days of the date of this notice. If you do not timely respond to this request, your rebuttal submission may be dismissed.

(If the submission is missing a signed written notice from the provider/supplier authorizing the legal representative to act on his/her/its behalf, use the following.) Your submission is missing a written notice of the appointment of a representative signed by the provider or supplier. [MAC Name] is requesting that you submit written notice of the appointment of a representative that is signed by the provider or supplier within 15 calendar days of the date of this notice. If you do not timely respond to this request, your rebuttal submission may be dismissed.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

B. Rebuttal Further Information Required Development Model Letter

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

To: [Email address provided by the person who submitted the rebuttal.]

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

[Month] [DD], [YYYY]

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

Re: Rebuttal Determination

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

NPI: [XXXXXXXXXX]

PTAN: [XXXX]

Reference Number: [XXXX] (Internal Tracking)

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

On [Month] [DD], [YYYY], [MAC Name] issued a favorable rebuttal determination, reversing the deactivation of [Provider/Supplier Name]'s Medicare billing privileges. As stated in the [Month] [DD], [YYYY] determination letter, the reactivation of [Provider/Supplier Name]'s Medicare enrollment is contingent upon the submission of [list required documentation]. Please send the required documentation to:

[MAC Rebuttal Receipt Address]

[MAC Rebuttal Receipt Email Address]

[MAC Rebuttal Receipt Fax Number]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]

[Position of Hearing Officer]

[MAC Name]

C. Rebuttal Moot Model Letter

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

To: [Email address provided by the person who submitted the rebuttal.]

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

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

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

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

[City], [State] [Zip Code]

Re: Rebuttal Determination

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

NPI: [XXXXXXXXXX]

PTAN: [XXXX]

Reference Number: [XXXX] (Internal Tracking)

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

This letter is in response to the rebuttal submission, received on [Month] [DD], [YYYY]. On [Month] [DD], [YYYY], [MAC Name] approved an application to reactivate [Name of

[Provider/Supplier]'s Medicare billing privileges without a gap. Therefore, the issue set forth in the rebuttal submission is no longer actionable. As a result, this issue is moot and a determination will not be made in regards to the rebuttal submission.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Signature of Hearing Officer] (May be electronic)

*[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]*

D. Rebuttal Withdrawn Model Letter

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

To: *[Email address provided by the person who submitted the rebuttal.]*

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

[Month] [DD], [YYYY]

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

Re: Rebuttal Determination

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

NPI: [XXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXX] (Internal Tracking)

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

We are in receipt of your written withdrawal request in regards to your rebuttal received on [Month] [DD], [YYYY]. [MAC Name] has not yet issued a rebuttal determination. Therefore, [MAC Name] considers your rebuttal to be withdrawn. As a result, a determination will not be issued in response to your rebuttal and your Medicare billing privileges will remain deactivated.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Signature of Hearing Officer] (May be electronic)

*[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]*

E. Rebuttal Receipt Acknowledgement Model Letter

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

To: [Email address provided by the person who submitted the rebuttal.]

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

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

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

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

[City], [State] [Zip Code]

Re: Rebuttal Determination

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

NPI: [XXXXXXXXXX]

PTAN: [XXXXX]

Reference Number: [XXXX] (Internal Tracking)

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

We are in receipt of your rebuttal on behalf of [Provider/Supplier Name]. Please be advised that [MAC Name] has made an interim determination to maintain the deactivation of your Medicare billing privileges. However, [MAC Name] will further review the information and documentation submitted in your rebuttal and will render a final determination regarding the deactivation of your Medicare billing privileges within 30 days of the date of receipt.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]

[Position of Hearing Officer]

[MAC Name]

F. Final Rebuttal Decision Email Template

To: [Email address provided by the person who submitted the rebuttal.]

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

(To be sent by hard-copy mail and email if email address is provided. Be sure to attach a copy of the final rebuttal determination in PDF format, if sent via email.)

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

Please see the attached determination regarding your rebuttal.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Signature of Hearing Officer] (May be electronic)

*[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]*

G. Rebuttal Dismissal Model Letters

1. Untimely Rebuttal Dismissal Model Letter

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

To: *[Email address provided by the person who submitted the rebuttal.]*

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

[Month] [DD], [YYYY]

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

Re: Rebuttal Determination

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

NPI: [XXXXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXX] (Internal Tracking)

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

This letter is in response to the rebuttal received by [MAC Name], based on the letter deactivating your Medicare billing privileges dated [Month] [DD], [YYYY].

[MAC Name] is unable to accept your rebuttal as it was not timely submitted. The deactivation letter was dated [Month] [DD], [YYYY]. A rebuttal must be received within 20 calendar days of the date of the [Month] [DD], [YYYY] deactivation letter. Your rebuttal was not received until [Month] [DD], [YYYY], which is beyond the applicable submission time frame. [Provider/Supplier/Legal Representative/Representative] failed to show good cause for its late request. Therefore, [MAC Name] is unable to render a determination in this matter and your Medicare billing privileges will remain deactivated.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

2. Improper Signature Rebuttal Dismissal Model Letter

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

To: [Email address provided by the person who submitted the rebuttal.]

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

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

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

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

[City], [State] [Zip Code]

Re: Rebuttal Determination

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

NPI: [XXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXX] (Internal Tracking)

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

This letter is in response to the rebuttal received by [MAC Name], based on the letter deactivating your Medicare billing privileges dated [Month] [DD], [YYYY].

[MAC Name] is unable to accept your rebuttal as it was not signed by an authorized or delegated official currently on file in your Medicare enrollment, the individual provider or supplier, a legal representative, or did not contain the required statement of representation from an attorney or signed written notice appointing a non-attorney legal representative. The signature requirement is stated in the [Month] [DD], [YYYY] deactivation letter. Please be advised that a properly signed rebuttal must be received within 20 calendar days of the date of the deactivation letter.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

3. No Rebuttal Rights Rebuttal Dismissal Model Letter

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

To: [Email address provided by the person who submitted the rebuttal.]

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

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

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

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

[City], [State] [Zip Code]

Re: Rebuttal Determination

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

NPI: [XXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXX] (Internal Tracking)

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

This letter is in response to the rebuttal received by [MAC Name].

[MAC Name] is unable to accept your rebuttal submission because the action taken in regards to your Medicare billing privileges does not afford the opportunity for a rebuttal. Under 42 C.F.R. § 424.545(b), only a provider or supplier whose Medicare billing privileges are deactivated may file a rebuttal in accordance with 42 C.F.R. § 405.374.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]

[Position of Hearing Officer]

[MAC Name]

4. More than One Submission Rebuttal Dismissal Model Letter

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

To: [Email address provided by the person who submitted the rebuttal.]

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

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

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

[Address](Address from which the rebuttal was sent)

[City], [State] [Zip Code]

Re: Rebuttal Determination

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)

NPI: [XXXXXXXXXX]

PTAN: [XXXXX]

Reference Number: [XXXX] (Internal Tracking)

Dear [Name of the person(s) who submitted the rebuttal]:

This letter is in response to the rebuttal received by [MAC Name], based on the deactivation letter dated [Month] [DD], [YYYY].

[MAC Name] previously received a rebuttal for [Provider/Supplier Name] on [Month] [DD], [YYYY]. Per Chapter 10 of the Medicare Program Integrity Manual, only one rebuttal request may be submitted per deactivation. Therefore, [MAC Name] is unable to accept your additional rebuttal[s] received on [Month] [DD], [YYYY].

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]

[Position of Hearing Officer]

[MAC Name]

H. Rebuttal Not Actionable Model Letter (Moot)

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

To: [Email address provided by the person who submitted the rebuttal.]

Subject: Medicare Provider Enrollment Rebuttal re: [Provider/Supplier Name]

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of Rebuttal] (If submitted on behalf of an organization or group)

[Address](Address from which the rebuttal was sent)

[City], [State] [Zip Code]

Re: Rebuttal Determination

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)

NPI: [XXXXXXXXXX]

PTAN: [XXXXX]

Reference Number: [XXXX] (Internal Tracking)

Dear [Name of the person(s) who submitted the rebuttal]:

This letter is in response to the rebuttal received by [MAC Name], concerning the deactivation of [Provider/Supplier Name]'s Medicare billing privileges, effective [Month] [DD], [YYYY].

On [Month] [DD], [YYYY], [MAC Name] reopened the deactivation for [Provider/Supplier Name] and issued a revised initial determination. This revised initial determination rendered

the issue set forth in your rebuttal no longer actionable. Accordingly, the issue addressed in your rebuttal is now moot, and we are unable to render a determination on the matter.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Signature of Hearing Officer] (May be electronic)

*[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]*

I. Favorable Rebuttal Model Letter

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

To: [Email address provided by the person who submitted the rebuttal.]

Subject: Medicare Provider Enrollment Rebuttal re: [Provider/Supplier Name]

[Month] [DD], [YYYY]

*[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal] (If submitted on behalf of an organization or group)
[Address](Address from which the Rebuttal was sent)
[City], [State] [Zip Code]*

Re: Rebuttal Determination

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)

NPI: [XXXXXXXXXX]

PTAN: [XXXXX]

Reference Number: [XXXX] (Internal Tracking)

Dear [Name of the Person(s) who submitted the rebuttal]:

This letter is in response to the rebuttal received by [MAC Name] based on the deactivation of [Provider/Supplier Name]'s Medicare billing privileges. The deactivation letter was dated [Month] [DD], [YYYY]; therefore, this rebuttal is considered timely. The following determination is based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

DEACTIVATION REASON:

42 C.F.R. § 424.540(a)(1-3)

OTHER APPLICABLE AUTHORITIES:

42 C.F.R. §

Medicare Program Integrity Manual (MPIM) chapter 10.XX (If applicable).

EXHIBITS:

- *Exhibit 1: (Example: Rebuttal letter to CMS, signed by John Smith, Administrator for Home Healthcare Services, LLC, dated January 1, 2018);*
- *Exhibit 2: (Example: Letter from MAC to Home Healthcare Services, LLC, dated December 1, 2017, deactivating Home Healthcare Services, LLC's Medicare billing privileges pursuant to 42 C.F.R. § 424.540(a)(3)).*

(In this section list each document submitted by the provider or supplier. Each exhibit should include the date, as well as a brief description of the document. You shall also include other documentation not submitted by the provider that the hearing officer reviewed in making the determination, e.g., enrollment applications, development letters, etc.)

BACKGROUND:

The documentation related to the matter for [Provider/Supplier Name] has been reviewed and the determination has been made in accordance with the applicable Medicare rules, policies and program instructions.

(Summarize the facts underlying the case which led up to the submission of the rebuttal.)

REBUTTAL ANALYSIS:

(A rebuttal reviews whether or not an error was made in the implementation of the deactivation of the provider's or supplier's Medicare billing privileges. This section should summarize the statements made by the provider or supplier in its rebuttal. Then conduct analysis of the arguments based on the applicable regulations and sub-regulations, MPIM. It is insufficient to state a rebuttal determination without explaining how and why the determination was made.)

DECISION:

(A short conclusory restatement.)

(Example: On [Month] [DD], [YYYY], [MAC Name] received a revalidation application for Home Healthcare Services, LLC. On [Month] [DD], [YYYY], [MAC Name] rejected Home Healthcare Services, LLC's revalidation application prior to 90 calendar days from the date of the revalidation request letter. As a result, [MAC Name] finds that the deactivation of Home Healthcare Services, LLC's Medicare billing privileges is not justified based on the information available.

*This decision is a **FAVORABLE DETERMINATION**. To effectuate this determination, [MAC name] will reinstate [Provider/Supplier Name]'s Medicare billing privileges.*

(If additional information is needed from the provider or supplier in order to reactivate the enrollment, the MAC shall state what information is needed from the provider or supplier in this rebuttal determination. MACs shall state that the requested information/documentation must be received within 30 calendar days of the date of this determination letter)

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]

[Position of Hearing Officer]

[MAC Name]

J. Unfavorable Rebuttal Model Letter

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

To: [Email address provided by the person who submitted the rebuttal.]

Subject: Medicare Provider Enrollment Rebuttal re: [Provider/Supplier Name]

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of Rebuttal] (If submitted on behalf of an organization or group)

[Address](Address from which the Rebuttal was sent)

[City], [State] [Zip Code]

Re: Rebuttal Determination

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)

NPI: [XXXXXXXXXX]

PTAN: [XXXXX]

Reference Number: [XXXX] (Internal Tracking)

Dear [Person(s) who submitted the rebuttal]:

This letter is in response to the rebuttal received by [MAC Name] based on the deactivation of [Provider/Supplier Name]'s Medicare billing privileges. The deactivation letter was dated [Month] [DD], [YYYY]; therefore, this rebuttal is considered timely. The following determination is based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

DEACTIVATION REASON:

42 C.F.R. § 424.540(a)(1-3)

OTHER APPLICABLE AUTHORITIES:

42 C.F.R. §

Medicare Program Integrity Manual chapter 10.XX (If applicable)

EXHIBITS:

- *Exhibit 1: (Example: Rebuttal letter to CMS, signed by John Smith, Administrator for Home Healthcare Services, LLC, dated January 1, 2018);*
- *Exhibit 2: (Example: Letter from MAC to Home Healthcare Services, LLC, dated December 1, 2017, deactivating Home Healthcare Services, LLC's Medicare billing privileges pursuant to 42 C.F.R. § 424.540(a)(3)).*

(In this section list each document submitted by the provider or supplier. Each exhibit should include the date, as well as a brief description of the document. You shall also include other documentation not submitted by the provider that the hearing officer reviewed in making the determination, e.g., enrollment applications, development letters, etc.)

BACKGROUND:

The documentation related to the matter for [Provider/Supplier Name] has been reviewed and the determination has been made in accordance with the applicable Medicare rules, policies, and program instructions.

[Summarize the facts underlying the case which led up to the submission of the rebuttal.]

REBUTTAL ANALYSIS:

(A rebuttal reviews whether or not an error was made in the implementation of the deactivation of the provider's or supplier's Medicare billing privileges. This section should summarize the statements made by the provider or supplier in its rebuttal. Then conduct analysis of the arguments based on the applicable regulations and sub-regulations, MPIM. It is insufficient to state a rebuttal determination without explaining how and why the determination was made.)

DECISION:

(A short conclusory restatement.)

(Example: On [Month] [DD], [YYYY], [MAC Name] received a revalidation application for Home Healthcare Services, LLC. On [Month] [DD], [YYYY], [MAC Name] sent a development request to continue processing Home Healthcare Services, LLC's revalidation application. Home Healthcare Services, LLC did not timely respond to [MAC Name]'s development request. As a result, [MAC Name] properly rejected Home Healthcare Services, LLC's revalidation application. Therefore, [MAC Name] finds that the deactivation of Home Healthcare Services, LLC's Medicare enrollment under 42 C.F.R. § 424.540(a)(1-3) is justified.)

*This decision is an **UNFAVORABLE DETERMINATION**. [MAC name] concludes that there was no error made in the deactivation of your Medicare billing privileges. As a result, your Medicare billing privileges will remain deactivated.*

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Signature of Hearing Officer] (May be electronic)

*[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]*

10.7.15 –Revalidation Notification Letters

(Rev. 10611; Issued: 03-19-21; Effective: 11-19-20; Implementation: 11-19-20)

A. Revalidation Letter

REVALIDATION

[month] [day], [year]

[Provider/Supplier Name]

[Address]

[City], [State] [Zip Code]

Dear [Provider/Supplier Name],

Every five years, CMS requires you to revalidate your Medicare enrollment record. You need to update or confirm all the information in your record, including your practice locations and reassessments.

We need this from you by [Due date, as Month dd yyyy]. If we don't receive your response by then, we may stop your Medicare billing privileges.

If you are a non-certified provider or supplier, and your enrollment is deactivated, you will maintain your original PTAN, however will not be paid for services rendered during the period of deactivation. This will cause a gap in your reimbursement.

What record needs revalidating by [Due date, as Month dd yyyy]

[Name] / NPI [NPI] / PTAN [PTAN]

Reassignments: <Only include this title if the record has any reassessments>

[Legal Business Name] / [dba Name] / Tax ID [Tax ID, mask all but last 4 digits]

<Repeat for other reassessments>

CMS lists the records that need revalidating at go.cms.gov/MedicareRevalidation.

What you need to do

Revalidate your Medicare enrollment record, through

<https://pecos.cms.hhs.gov/pecos/login.do> or [form CMS-855 or Form CMS-20134].

- **Online:** PECOS is the fastest option. If you don't know your username or password, PECOS offers ways to retrieve them. Our customer service can also help you by phone at 866-484-8049.
- **Paper:** Download the right version of form [CMS-855 or Form CMS-20134] for your situation at cms.gov. We recommend getting proof of receipt for your mailing. Mail to [contractor address].

If you have a fee due, use PECOS to pay. If you feel you qualify for a hardship waiver, mail us a request on practice letterhead with financial statements, application form, and certification. For more on fees and exceptions, search cms.gov for “CR 7350” or “Fee Matrix”.

A new Electronic Funds Transfer (EFT) Authorization Form (CMS-588) is only required to be submitted as part of your revalidation package if the current version, approved by the Office of Management and Budget (OMB), is not on file with Medicare. The current version of the form can be found at <http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS588.pdf>.

If you need help

Visit go.cms.gov/MedicareRevalidation

Call [contractor phone #] or visit [contractorsite.com] for more options.

Sincerely,
[Name]
[Title]
[Company]

B. Revalidation Letter – CHOW Scenario Only

[month] [day], [year]

*PROVIDER/SUPPLIER NAME
ADDRESS 1, ADDRESS 2
CITY STATE ZIP CODE*

*NPI:
PTAN:*

Dear Provider/Supplier Name:

THIS IS A PROSPECTIVE PROVIDER ENROLLMENT REVALIDATION REQUEST

**IMMEDIATELY SUBMIT AN UPDATED
PROVIDER ENROLLMENT PAPER APPLICATION 855 FORM TO VALIDATE YOUR
ENROLLMENT INFORMATION**

In accordance with Section 6401 (a) of the Patient Protection and Affordable Care Act, all new and existing providers must be reevaluated under the new screening guidelines. Medicare requires all enrolled providers and suppliers to revalidate their enrollment information every five years (reference 42 CFR §424.515). To ensure compliance with these requirements, existing regulations at 42 CFR §424.515(d) provide that the Centers for Medicare & Medicaid Services (CMS) is permitted to conduct off-cycle revalidations for certain program integrity purposes. Upon the CMS request to revalidate its enrollment, the provider/supplier has 60 days from the post mark date of this letter to submit complete enrollment information.

You previously submitted a change of ownership (CHOW) application that is currently being reviewed by the CMS Regional Office (RO) and the State Agency. Since your application has not been finalized, please validate that we have the most current information on file. Any updated information received since your initial submission will be forwarded to the CMS RO and the State Agency for their final determination.

Providers and suppliers can validate their provider enrollment information using the paper application form. To validate by paper, download the appropriate and current CMS-855 Medicare Enrollment application from the CMS Web site at <https://www.cms.gov/MedicareProviderSupEnroll/>. Mail your completed application and all required supporting documentation to the [insert contractor name], at the address below.

[Insert application return address]

A new Electronic Funds Transfer (EFT) Authorization Form (CMS-588) is only required to be submitted as part of your revalidation package if the current version, approved by the Office of Management and Budget (OMB), is not on file with Medicare. The current version of the form can be found at <http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS588.pdf>.

If additional time is required to complete the validation applications, you may request one 60-day extension, which will be added onto the initial 60 days given to respond to the request. The request may be submitted in writing from the individual provider, the Authorized or Delegated Official of the organization or the contact person and addressed to the MAC(s). The request should include justification of why a 60-day extension is needed. The request may also be made by contacting your MAC(s), via phone.

Physicians, non-physician practitioners and physician and non-physician practitioner organizations must report a change of ownership, any adverse legal action, or a change of practice location to the MAC within 30 days. All other changes must be reported within 90 days. For most but not all other providers and suppliers, changes of ownership or control, including changes in authorized official(s) must be reported within 30 days; all other changes to enrollment information must be made within 90 days.

Failure to submit complete enrollment application(s) and all supporting documentation within 60 calendar days of the postmark date of this letter may result in your Medicare billing privileges being deactivated and your CHOW not being processed. We strongly recommend you mail your documents using a method that allows for proof of receipt.

If you have any questions regarding this letter, please call [contractor telephone number will be inserted here] between the hours of [contractor telephone hours will be inserted here] or visit our Web site at [insert Web site] for additional information regarding the enrollment process or the [insert application type].

*Sincerely,
[Your Name]
[Title]*

C. Large Group Revalidation Notification Letter

[month] [day], [year]

*PROVIDER/SUPPLIER GROUP NAME
ADDRESS 1, ADDRESS 2
CITY STATE ZIP CODE*

*NPI:
PTAN:*

Dear Provider/Supplier Group Name:

THIS IS NOT A PROVIDER ENROLLMENT REVALIDATION REQUEST

This is to inform you that a number of physicians and/or non-physician practitioners reassigning all or some of their benefits to your group have been selected for revalidation. For your convenience, a list of those individuals is attached. A revalidation notice will be sent to the physician or non-physician practitioner within the next seven months. They will need to respond by the revalidation due date provided for each provider. It is the responsibility of the physician and/or non-physician practitioner to revalidate all their Medicare enrollment information and not just that associated with the reassignment to your group practice.

In accordance with Section 6401 (a) of the Patient Protection and Affordable Care Act, all new and existing providers must be reevaluated under the new screening guidelines. Medicare requires all enrolled providers and suppliers to revalidate their enrollment

information every five years (reference 42 CFR §424.515). To ensure compliance with these requirements, existing regulations at 42 CFR §424.515(d) provide that the Centers for Medicare & Medicaid Services (CMS) is permitted to conduct off-cycle revalidations for certain program integrity purposes.

Physicians and non-physician practitioners can revalidate by using either Internet-based PECOS or submitting a paper CMS-855 enrollment application. Failure to submit a complete revalidation application and all supporting documentation within 60 calendar days may result in the physician or non-physician practitioner's Medicare billing privileges being deactivated. As such, your group will no longer be reimbursed for services rendered by the physician or non-physician practitioner.

If you have any questions regarding this letter, please call [contractor telephone number will be inserted here] between the hours of [contractor telephone hours will be inserted here] or visit our Web site at [insert Web site] for additional information regarding the revalidation process.

Sincerely,

[Your Name]
[Title]

D. Revalidation Pend Letter

PAYMENT HOLD

[month] [day], [year]

[Provider/Supplier Name]
[Address]
[City], [State] [Zip Code]

Dear [Provider/Supplier Name],

We are holding all payments on your Medicare claims, because you haven't revalidated your enrollment record with us. This does not affect your Medicare participation agreement, or any of its conditions.

Every [three or five years], CMS requires you to revalidate your Medicare enrollment record information. You need to update or confirm all the information in your record, including your practice locations and reassessments.

Failure to respond to this notice will result in a possible deactivation of your Medicare enrollment. If you are a non-certified provider or supplier, and your enrollment is deactivated, you will maintain your original PTAN, however will not be paid for services rendered during the period of deactivation. This will cause a gap in your reimbursement.

What record needs revalidating

[Name] / NPI [NPI] / PTAN [PTAN]

Reassignments:

[Legal Business Name] / [dba Name] / Tax ID [Tax ID, mask all but last 4 digits]
<Repeat for other reassessments>

CMS lists the records that need revalidating at go.cms.gov/MedicareRevalidation.

How to resume your payments

***Revalidate your Medicare enrollment record, through
<https://pecos.cms.hhs.gov/pecos/login.do> or [form CMS-855 or Form CMS-20134].***

- ***Online:*** *PECOS is the fastest option. If you don't know your username or password, PECOS offers ways to retrieve them. Our customer service can also help you by phone at 866-484-8049.*
- ***Paper:*** *Download the right version of [form CMS-855 or Form CMS-20134] for your situation at cms.gov. We recommend getting proof of receipt for your mailing. Mail to [contractor address].*

If you have a fee due, use PECOS to pay. If you feel you qualify for a hardship waiver, mail us a request on practice letterhead with financial statements, application form, and certification.

If you need help

Visit go.cms.gov/MedicareRevalidation

Call [contractor phone #] or visit [contractorsite.com] for more options.

*Sincerely,
[Name]
[Title]
[Company]*

E. Revalidation Deactivation Letter

STOPPING BILLING PRIVILEGES

[month] [day], [year]

*[Provider/Supplier Name]
[Address]
[City], [State] [Zip Code]*

Dear [Provider/Supplier Name],

Your Medicare billing privileges are being deactivated effective [Month] [DD], [YYYY], pursuant to 42 C.F.R. § 424.540(a)(3) because you have not timely revalidated your enrollment record with us, or your revalidation application has been rejected because you did not timely respond to our requests for more information. We will not pay any claims after this date.

Every five years [three for the NSC], CMS requires you to revalidate your Medicare enrollment record.

What record needs revalidating

[Name] / NPI [NPI] / PTAN [PTAN]

Reassignments:

*[Legal Business Name] / [dba Name] / Tax ID [Tax ID, mask all but last 4 digits]
<Repeat for other reassignments>*

CMS lists the records that need revalidating at <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Revalidations.html>.

REBUTTAL RIGHTS:

If you believe that this determination is not correct, you may rebut the deactivation as indicated in 42 C.F.R. § 424.545. The rebuttal must be received by this office in writing within 20 calendar days of the date of this letter. The rebuttal must state the issues or findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the rebuttal that you believe may have a bearing on the decision. You must submit all information that you would like to be considered in conjunction with the rebuttal. This includes any application(s) to update your enrollment, if necessary. You may only submit one rebuttal in response to this deactivation of your Medicare enrollment.

The rebuttal must be signed and dated by the individual provider/supplier, the authorized or delegated official, or a legal representative.

If the provider/supplier wishes to appoint a legal representative that is not an attorney to sign the rebuttal, the provider/supplier must include with the rebuttal a written notice authorizing the legal representative to act on the provider/supplier's behalf. The notice should be signed by the provider/supplier.

If the provider/supplier has an attorney sign the rebuttal, the rebuttal must include a statement from the attorney that he/she has the authority to represent the provider/supplier.

If you wish to receive communication regarding your rebuttal via email, please include a valid email address in your rebuttal request.

The rebuttal should be sent to the following:

[MAC Rebuttal Receipt Address]

[MAC Rebuttal Receipt Email Address]

[MAC Rebuttal Receipt Fax Number]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

How to recover your billing privileges

Revalidate your Medicare enrollment record, through PECOS.cms.hhs.gov, or [form CMS-855 or Form CMS-20134].

- Online: PECOS is the fastest option. If you don't know your username or password, PECOS offers ways to retrieve them. Our customer service can also help you by phone at 866-484-8049.*
- Paper: Download the right version of [form CMS-855 or Form CMS-20134] for your situation at cms.gov. We recommend getting proof of receipt for your mailing. Mail to [contractor address].*

If you have a fee due, use PECOS to pay. If you feel you deserve a hardship waiver, mail us a request on practice letterhead with financial statements, application form, and certification.

If you are a non-certified provider or supplier, and your enrollment is deactivated, you will maintain your original PTAN, however will not be paid for services rendered during the period of deactivation. This will cause a gap in your reimbursement.

If you need help

Visit <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Revalidations.html>.

Call [contractor telephone number] or visit [contractorsite.com] for more options.

Sincerely,

[Name]

[Title]

[Company]

F. Revalidation Past-Due Group Member Letter

REVALIDATION / Past-Due Group Member

[month] [day], [year]

[Provider/Supplier Name]

[Address]

[City], [State] [Zip Code]

Dear [Provider/Supplier Name],

Every five years, CMS requires providers to revalidate their Medicare enrollment records. You have not revalidated by the requested due date of [revalidation due date].

You need to update or confirm all the information in your record, including your practice locations and reassessments. If you are a non-certified provider or supplier, and your enrollment is deactivated, you will maintain your original PTAN, however will not be paid for services rendered during the period of deactivation. This will cause a gap in your reimbursement.

If multiple records below need to be revalidated, please coordinate with the appropriate parties to provide only one response.

What record needs revalidating

[Name] / NPI [NPI] / PTAN [PTAN]

Reassignments: <Only include this title if the record has any reassessments>

[Legal Business Name] / [dba Name] / Tax ID [Tax ID, mask all but last 4 digits]

<Repeat for other reassessments>

CMS lists the records that need revalidating at go.cms.gov/MedicareRevalidation.

What your group member needs to do

Revalidate their Medicare enrollment record, through

<https://pecos.cms.hhs.gov/pecos/login.do>, or [form CMS-855 or Form CMS-20134].

- **Online:** PECOS is the fastest option. If they don't know their username or password, PECOS offers ways to retrieve them. Our customer service can also help by phone at 866-484-8049.*

- **Paper:** Download the right version of [form CMS-855 or Form CMS-20134] for their situation at cms.gov. We recommend getting proof of receipt for this mailing. Mail to [contractor address].

If your group member needs help

Visit go.cms.gov/MedicareRevalidation

Call [contractor phone #] or visit [contractorsite.com] for more options.

Sincerely,

[Name]

[Title]

[Company]

G. Model Return Revalidation Letter

RETURN REVALIDATION

[month] [day], [year]

[Provider/Supplier Name]

[Address]

[City], [State] [Zip Code]

Dear [Provider/Supplier Name],

Your Medicare enrollment application(s) was received on [date]. We are closing this request and returning your application(s) for the following reason(s):

- The [form CMS-855 or Form CMS-20134] application received by [PROVIDER/SUPPLIER NAME] was unsolicited.
 - An unsolicited revalidation is one that is received more than seven months prior to the provider/supplier's due date. Due dates are established around 5 years from the provider/suppliers last successful revalidation or their initial enrollment.
 - To find the provider/suppliers revalidation due date, please go to <http://go.cms.gov/MedicareRevalidation>.
 - If you are not due for revalidation in the current seven month period, you will find that your due date is listed as "TBD" (or To Be Determined). This means that you do not yet have a due date for revalidation within the current seven month period. This list will be updated monthly.
- If your intention is to change information on your Medicare enrollment file, you must complete a new Medicare enrollment application(s) and mark 'change' in section 1 of the [form CMS-855 or Form CMS-20134].
- Please address the above issues as well as sign and date the new certification statement page on your resubmitted application(s).

Providers and suppliers can apply to enroll in the Medicare program using one of the following two methods:

1. Internet-based Provider Enrollment, Chain and Organization System (PECOS). Go to: <https://pecos.cms.hhs.gov/pecos/login.do>.

2. Paper application process: Download and complete the Medicare enrollment application(s) at <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/EnrollmentApplications.html>. DMEPOS suppliers should send the completed application to the National Supplier Clearinghouse (NSC).

If you need help

Visit <http://go.cms.gov/MedicareRevalidation>, or
Call [contractor phone #] or visit [contractorsite.com] for more options.

Sincerely,
[Name]
[Title]
[Company]

10.7.17 – Model Identity Theft Prevention Letter
(Rev. 10611; Issued: 03-19-21; Effective: 11-19-20; Implementation: 11-19-20)

[month] [day], [year]

[Provider/Supplier Name]
[Address]
[City] ST [Zip]

Reference # (PTAN #, Enrollment #, Case #, etc.)

Dear [Provider/Supplier Name]:

As a security precaution, we are writing to confirm that you submitted a Medicare enrollment application(s) to enroll in or change an existing enrollment at the following address:

[Provider/Supplier Name]
[Address]
[City] ST [Zip]

If this application was submitted without your authorization, please contact the Medicare contractor that processes your claims immediately. The Medicare Fee-For-Service contact information can be found at www.cms.hhs.gov/MedicareProviderSupEnroll.

We will process your application(s) according to The Centers for Medicare & Medicaid (CMS) timeliness standards and will contact you if additional information is needed. We will notify you once processing is complete.

Please contact our office with any questions at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM] and refer to your application(s) reference number [Reference number]

Sincerely,

[Name]
[Title]
[Company]

10.7.18 - Model Documentation Request Letter
(Rev. 10611; Issued: 03-19-21; Effective: 11-19-20; Implementation: 11-19-20)

A. Model Language for §424.516(f)(1) Situations

The contractor shall use the model language below if it is requesting documentation from a provider or supplier furnishing the items or services addressed in §424.516(f)(1).

“Dear Provider/Supplier:

Under 42 CFR §424.516(f)(1), a provider or supplier that furnishes covered ordered items of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS), clinical laboratory, imaging services, or covered ordered/certified home health services is required to:

- Maintain documentation for 7 years from the date of service, and*
- Upon the request of CMS or a Medicare contractor, provide access to that documentation.*

The documentation to be maintained includes written and electronic documents (including the National Provider Identifier (NPI) of the physician who ordered/certified the home health services and the NPI of the physician - or, when permitted, other eligible professional - who ordered items of DMEPOS or clinical laboratory or imaging services) relating to written orders and certifications and requests for payments for items of DMEPOS and clinical laboratory, imaging, and home health services.

Consistent with §424.516(f)(1), please mail to us copies of the orders for the items or services that were furnished to the following beneficiaries on the dates specified:

(Contractors shall insert the beneficiaries’ names (up to 5 may be listed, unless CMS specifies otherwise), appropriate identification information, and the dates on which the provider or supplier furnished the items/services in question. The contractor has the discretion to determine the cases/services that are included in this documentation request as well as the type(s) of documentation to be requested.)

The documentation must be received at the following address no later than 30 calendar days after the date of this letter:

(Cite appropriate address)

Failure to timely submit this documentation may result in the revocation of your enrollment pursuant to 42 CFR §424.535(a)(10).”

Please contact our office with any questions at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM] and refer to your application(s) reference number [Reference number]

Sincerely,

*[Name]
[Title]
[Company]*

B. Model Language for §424.516(f)(2) Situations

The contractor shall use the model language below if it is requesting documentation from a provider or supplier furnishing the items or services addressed in § 424.516(f)(2).

“Dear Physician/Professional:

Under 42 CFR §424.516(f)(2), a physician who orders/certifies home health services and the physician - or, when permitted, other eligible professional - who orders items of DMEPOS or clinical laboratory or imaging services is required to maintain documentation for 7 years from the date of service and to provide access to that documentation pursuant to a CMS or Medicare contractor request. The documentation to be maintained includes written and electronic documents relating to written orders and certifications and requests for payments for items of DMEPOS and clinical laboratory, imaging, and home health services.

Consistent with §424.516(f)(2), please mail to us copies of the orders for items or services that you issued for the following beneficiaries on the dates specified:

(Contractors shall insert the beneficiaries’ names (up to 5 may be listed, unless CMS specifies otherwise), appropriate identification information, and the dates on which the orders were made. The contractor has the discretion to determine the cases/services that are included in this documentation request as well as the type(s) of documentation to be requested.)

The documentation must be received at the following address no later than 30 calendar days after the date of this letter:

(Cite appropriate address)

Failure to timely submit this documentation may result in the revocation of your enrollment pursuant to 42 CFR §424.535(a)(10).” (For individuals enrolled via the Form CMS-855O, the contractor shall instead use the following language: “Failure to timely submit this documentation may result in the revocation of your Form CMS-855O enrollment.”)

Please contact our office with any questions at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM] and refer to your application(s) reference number [Reference number]

Sincerely,

*[Name]
[Title]
[Company]*

Medicare Program Integrity Manual

Chapter 15 – *Reserved for Future Use*

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Not Added to Revamp - Chapter 15 Section was a header with no instruction was "Reserved for Future Use"

New to Revamp - This section did not exist in Chapter 15