CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-08 Medicare Program Integrity	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 10828	**Date: June 11, 2021**
	Change Request 12248

SUBJECT: Provider Enrollment Rebuttal Process - Additional Instructions for Returning Applications and Deactivations

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to clarify Medicare Administrative Contractor (MAC) procedures for returning enrollment applications and implementing enrollment deactivations.

EFFECTIVE DATE: July 12, 2021
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 12, 2021

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	10/10.4/Medicare Enrollment: Contractor Processing Duties

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

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I. GENERAL INFORMATION

A. Background: As part of CR10978, CMS implemented the provider enrollment rebuttal process and provided clarification on existing deactivation policy. This CR provides additional clarification for deactivation policy under 42 Code of Federal Regulations (C.F.R.) 424.540(a)(2), as well as a Model Return Reason for applications submitted for favorable rebuttal decisions.

B. Policy: 42 C.F.R. 424.540(a)(2) and 424.545(b).

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
12248.1	The contractor shall only deactivate a provider's or supplier's Medicare enrollment record under 42 CFR 424.540(a)(2) if no other instruction provides for a revocation action.	X	X	X						NSC
12248.1.1	The contractor shall review to determine if the provider or	X	X	X						NSC

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	supplier fails to timely report a change in ownership or control within 30 calendar days, or a change to any other information on the enrollment application within 90 days.									
12248.1.2	The contractor shall deactivate under 424.540(a)(2) once it has reviewed to determine that an applicable change has not been timely reported and verified that no Medicare enrollment application has been submitted to properly report the change prior to any administrative action being taken.	X	X	X						NSC
12248.1.2.1	The contractor shall process a Medicare	X	X	X						NSC

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	enrollment application that is attempting to report a change to the Medicare enrollment if recieved prior to an administrative action taking place without deactivating the provider's or supplier's enrollment record.									
12248.2	The contractor shall return any application(s) received while the rebuttal submission was being reviewed or during the rebuttal submission timeframe that have not been processed to completion, if a rebuttal determination overturns the deactivation, unless the application is needed to reactivate the enrollment or there are new changes being	X	X	X						NSC

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	reported.									

III. PROVIDER EDUCATION TABLE

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

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): Rebecca Grandfield, 410-786-4972 or rebecca.grandfield@cms.hhs.gov

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

VI. FUNDING

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

ATTACHMENTS: 0

Medicare Program Integrity Manual
Chapter 10 - Medicare Enrollment

Table of Contents
(Rev. 10828; Issued: 06-11-21)

10.4 – Medicare Enrollment: Contractor Processing Duties

(Rev.10828; Issued: 06-11-21; Effective: 07-12-21; Implementation: 07-12-21)

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), 10.1(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.palmettogba.com/pgx_palmettogbacom/initStatusLetter.do and provide the requested information to receive a copy of the supplier's approval letter.

H. Application Returns, Rejections and Denials

1. Returns

a. Reasons for Return

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

- The applicant sent its paper Form CMS-855 or CMS-20134 to the wrong contractor (e.g., the application was sent to Contractor X instead of Contractor Y).

- The contractor received the 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 60 days prior to the anticipated date of the sale. (This only applies to Form CMS-855A applications.)

- The contractor can confirm that the provider or supplier submitted an initial enrollment application prior to the expiration of the time period

in which it is entitled to appeal the denial of its previously submitted application, or

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

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

- The application is to be returned per the instructions in 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*, CMS-588,* 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/FISS or PECOS, whenever possible.

3. Non-Response to Revalidation Actions

a. Phone Calls

Contractors may continue to contact providers/suppliers via telephone or email to communicate non-receipt of revalidation applications; however, these contacts are not required.

If telephone or email contacts are made, contractors shall continue to document all communications with the providers/suppliers.

b. Pend Status

Contractors shall apply the payment hold (pend flag) in PECOS if the provider/supplier fails to respond to the revalidation request. MACs shall perform this action within 25 days after the revalidation due date. Contractors may, but are not required to notify the provider/supplier of the payment hold.

Since there is no way to assign a payment hold to an individual group member without it preventing payment to the entire group, contractors shall issue a letter to the individual group members in lieu of the payment hold within 25 days after the revalidation due date using the sample letter provided in 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 either the 05/2010 or later 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 reassignments and/or employment arrangements, the contractor shall develop to the contact person (or the individual provider if a contact is not listed), for the remaining reassignments and/or employment arrangements not accounted for. If no response is received within 30 days, the contractor shall revalidate the single reassignment and deactivate the reassignments and/or employment arrangements within the enrollment records that were not revalidated.

The deactivation date shall be consistent with the latter of: (1) the revalidation due date, or (2) the date deactivation action is taken due to non-response or incomplete response to a development request for all provider and supplier business structures (i.e. organizations, sole proprietors, sole owners, etc.).

To illustrate, in scenario #1 the contractor issues a revalidation notice to the provider and includes reassignments and/or employment arrangements for Groups A, B & C. The provider submits the revalidation application to the contractor but only addresses the reassignment for Group A. The contractor develops to the contact person for the missing reassignments and/or employment arrangements for Groups B & C. The provider responds with the reassignment information for Groups B & C prior to the development due date. Since the revalidation application is still considered in progress, the provider may submit a full 855I or sections 1, 2, 4, & 15 of the 855I to report the missing reassignment information, even post revalidation application approval. The revalidation application is processed to completion and the provider experiences no break in billing.

In scenario #2 the contractor issues a revalidation notice to the provider and includes reassignments and/or employment arrangements for Groups A, B & C. The provider submits the revalidation application to the contractor but only addresses the reassignment for Group A. The contractor develops to the contact person for the missing reassignments and/or employment arrangements for Groups B & C. No response is received within 30 days and the revalidation due date has passed.

Group A's reassignment is revalidated. Group B & C's reassignments and/or employment arrangements are deactivated effective with the date deactivation action is taken due to non-response or incomplete response to a development request. The approval letter issued by the contractor will identify the reassignments and/or employment arrangements that were revalidated and those terminated with the effective date of the reassignment or termination. The provider is required to submit a full application (CMS-855R) to reactivate the reassignment. The effective date for the reactivation is based on the receipt date of the CMS-855R. In this scenario the provider does experience a break in billing.

In this scenario, the entire enrollment shall not be deactivated; only the non- response reassignments and/or employment arrangements shall be deactivated and the other reassignments and/or employment arrangements revalidated.)

If other missing information is not received within 30 days, contractors shall deactivate the provider/supplier within 25 days after the development due date and notify the provider/supplier of the deactivation using the sample letter provided in 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 surveyor accreditation as a condition of revalidation.

8. Change of Information Received Prior to or After the Revalidation Letter is Mailed

If a change of information (COI) application is received from the provider/supplier prior to the contractor having mailed the revalidation letter, the contractor shall process the COI as normal and proceed with mailing the revalidation notice.

If the provider/supplier submits an application marked as a revalidation but only includes enough information to be considered a COI, the contractor shall (1) develop for a complete application containing the missing data elements, and (2) treat it as a revalidation.

If a change of information (COI) application is received after the contractor has mailed the revalidation notice, the contractor shall (1) develop for a complete application containing the missing data elements, and (2) treat it as a revalidation.

9. Reassignments and/or Employment Arrangement Applications Received After Revalidation Letter Mailed

If the revalidation due date has been posted (7 months prior to revalidation due date) and a reassignment and/or employment arrangement application has been received within that 7 month timeframe, contractors shall process the reassignment and/or employment arrangement application. The newly established reassignment/employment arrangement is not required to be reported on the revalidation application and contractors shall not develop for the missing information, since they were established after the revalidation notice was issued. Contractors shall however, maintain the reassignment/employment arrangement information in the enrollment record when processing the revalidation application and this information shall not be overridden. In the instance where the provider or supplier fails to respond to the revalidation request, all reassignments/employment arrangements shall be end dated, including the newly established reassignment/employment arrangement.

To illustrate, Dr. Doe submits a CMS-855R application to his contractor to add a new reassignment to Browns Medical Center. Soon after he checks https://data.cms.gov/revalidation and notices that he is due for revalidation in the next 7 months. He submits his revalidation application to his contractor but does not include the reassignment for Browns Medical Center since it is in progress and an approval notification has not been issued. The contractor finalizes the reassignment changes and then proceeds with processing the revalidation application. The contractor shall not develop for the new reassignment to Browns Medical Center and shall maintain the reassignment in the provider's enrollment record when processing the revalidation application.

If a revalidation and change of information application is received concurrently, the contractors shall merge the two applications and process accordingly.

10. Revalidating Providers Involved in a Change of Ownership (CHOW)

Contractors shall not take revalidation actions on providers or suppliers that are undergoing a CHOW that is currently in process by the contractor or pending review by the State/RO. Contractors shall notify their Provider Enrollment Oversight Group (PEOG) Business Function Lead (BFL) if a seller enrollment record is up for revalidation and the CHOW application is currently in process by the contractor. Contractors shall include the seller and buyer enrollment record ID in their email notification to their PEOG BFL.

11. Large Group Revalidation Coordination

In addition to providing the finalized revalidation list with contractor confirmed due dates, CMS will provide a list of large groups affected by this notification, including the individual providers reassigning benefits to their group that appear on the 6 month list. Contractors may stagger the large group mailings however they see fit to ensure the group receives notification

that providers within their group will be receiving a request to revalidate in the next 7 months. Contractors shall send the notification letter to the Authorized/Delegated Official or the enrollment contact person. Contractors may send the group notices via email utilizing the email addresses provided as part of the CMS list (derived from Section 2 and 13 of PECOS).

Contractors shall indicate **"IMPORTANT: Group Notification of Upcoming Provider Enrollment Revalidation Request"** in the subject line to differentiate this from other emails. Contractors shall use the sample letter provided in 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 reassignments. Groups with less than 200 reassignments will not appear on the list and are not required to be emailed or mailed a group notification letter; however, all reassignment information will be available at https://data.cms.gov/revalidation for providers and suppliers to view.

Contractors shall designate an enrollment analyst for each of the large groups to coordinate revalidation activities. The designated enrollment analyst shall be identified on the group notification letter. The enrollment analysts shall work directly with the group's enrollment contact person or the Authorized/Delegated Official on file.

Contractors shall allow large groups to submit a spreadsheet identifying those providers that are no longer practicing at their group in lieu of submitting CMS-855R termination applications. The spreadsheet shall be accompanied by a letter signed by the Authorized/Delegated Official of the group. This process is only acceptable for large groups who are completing their revalidation and coordinating directly with the contractor.

12. Finalizing the Revalidation Application

Prior to processing the revalidation application to completion, the contractor shall ensure that:

- A site visit (if applicable to the provider/supplier in question) is requested to be conducted by the National Site Visit Contractor (NSVC)

- The provider/supplier meets all applicable federal regulatory requirements regarding licensure, certification and/or educational requirements, as listed in the Code of Federal Regulations (CFR) and as described in CMS Publication 100-02 for his or her supplier type.

- The provider/supplier's information is revalidated based on the information in PECOS.

- Practice locations continue to be verified; however, there is no need to contact each and every location separately. Verification shall be done with the contact person listed on the application and noted accordingly in the contractor's verification documentation per section 10.4(C) of this chapter.

- The appropriate logging & tracking (L&T) record type and finalization status are identified in PECOS.

- An enrollment record is not marked as revalidated in PECOS if responses have been received for some PTANs yet not all PTANs have been addressed (meaning that no action has been taken on the non-response PTANs, i.e., end-dated). If all PTANs have been addressed (i.e., revalidated, end-dated), the enrollment can be marked as revalidated.

- PECOS and the claims systems remain in sync. The contractor shall not directly update the shared systems without first updating PECOS when processing a revalidation unless instructed otherwise in another CMS directive.

- When processing of the revalidation application is complete, contractors shall issue an approval letter to the contact person or the provider/supplier if a contact person is not listed, via mail, fax, or email. If the provider/supplier has reassignments that were terminated due to non-response, the approval letter shall contain the reassignments that were terminated due to non-response and the effective date of termination (i.e., the revalidation due date or the development due date).

13. Revalidation Reporting

Contractors are no longer required to submit reports on the 5th and 20th of each month for Cycle 2. However, contractors shall maintain internally the method of delivery for the provider/supplier revalidation notices and the date the email or letter was sent. CMS may periodically request ad hoc reporting of this data. The data elements for ad-hoc reporting shall include, but is not limited to the following; revalidation notification delivery date, delivery method, delivery address, deactivation date, provider response date, reactivation date, application finalization date, etc.

14. Revalidation Files Available Online

The revalidation due dates are available at https://data.cms.gov/revalidation via the Revalidation look up tool. The tool includes all enrolled providers/suppliers. Those due for revalidation will display a revalidation due date, all other providers/suppliers not up for revalidation will display a "TBD" (To Be Determined) in the due date field. In addition, a crosswalk to the organizations that the individual provider reassigns benefits will also be available at https://data.cms.gov/revalidation on the CMS website.

15. Revalidation Extension Requests

Contractors shall only accept extension requests from a provider or supplier that was not given the full seven months advance notice prior to their revalidation due date as a result of

the due date list being untimely posted to the CMS website. Contractors shall no longer accept extension requests from the providers or suppliers for any other reason.

If there is a delay in posting the above referenced list, which impacts a provider or supplier receiving the full 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 MACRevocationRequests@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

- Reenrollment Bar information

- Information regarding the provider/supplier's appeal rights

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.

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 professionals 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 *in ownership or control, as specified in § 424.550(b)* within *30 calendar days of when the change occurred, or* 90 calendar days of when the change occurred *for all other information on the enrollment application*. Changes that must be reported *within 90 calendar days* 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~~. *To clarify, if a provider or supplier submits a change of information application indicating a change that was not reported within 90 days of the change occurring and the MAC did not previously take administrative action against the enrollment and no revocation action is applicable under current instruction, the MAC should process the change of information application without deactivating the provider's or supplier's enrollment.*

- 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*, or if there are new changes being reported*. 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 acknowledgment 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 it 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 contactor 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 contactor 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 a rebuttal determination overturns the deactivation, the contractor shall return any application(s) received while the rebuttal submission was being reviewed or during the rebuttal submission timeframe that have not been processed to completion, unless the application is needed to reactivate the enrollment or if there are new changes being reported. If the contractor confirms that the application is not needed and that no new changes are being reported, then the contractor shall use the following return reason in the Returned Application Model Letter found at 10.7.7.A of this chapter in response to the scenario described above: "A rebuttal decision has been issued; therefore, the submitted Form CMS [855/588/20134] is not needed."

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.