| CMS Manual System | **Department of Health & Human Services (DHHS)** |
|---|---|
| Pub 100-08 Medicare Program Integrity | **Centers for Medicare & Medicaid Services (CMS)** |
| **Transmittal 11020** | **Date: October 1, 2021** |
| | **Change Request 12412** |

**SUBJECT: Restructuring of Section 10.4 in Chapter 10 of Publication (Pub.) 100-08**

**I. SUMMARY OF CHANGES:** The purpose of this Change Request (CR) is to split Section 10.4 in Chapter 10 of Pub. 100-08 into numerous subsections. The changes in this CR are structural and organizational in nature. Any necessary policy changes or significant clarifications involving the instructions in Section 10.4 will be made via subsequent CRs.

**EFFECTIVE DATE: October 29, 2021**
**Unless otherwise specified, the effective date is the date of service.*
**IMPLEMENTATION DATE: October 29, 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/Table of Contents |
| D | 10/10.2/10.2.1.15/Miscellaneous Policies |
| R | 10/10.2/10.2.3/Individual Practitioners Who Enroll Via the Form CMS-855I |
| R | 10/10.4/Medicare Enrollment - Contractor Processing Duties and Related Policies |
| N | 10/10.4/10.4.1/General Processing Functions |
| N | 10/10.4/10.4.1.1/Overview of the Process |
| N | 10/10.4/10.4.1.2/Receipt of Application |
| N | 10/10/4/10.4.1.3/Review of Application |
| N | 10/10.4/10.4.1.3.1/Initial Steps of Review of Application |
| N | 10/10.4/10.4.1.3.2/Data Verification |
| N | 10/10.4/10.4.1.3.3/Requesting Missing/Clarifying Data/Documentation (Development) |
| N | 10/10.4/10.4.1.3.4/Receiving Missing/Clarifying Data/Documentation (Response to Development) |
| N | 10/10.4/10.4.1.3.5/Provider/Supplier Fails to Submit Requested Data/Documentation |
| N | 10/10.4/10.4.1.4/Application Disposition |
| N | 10/10.4/10.4.1.4.1/Approvals |
| N | 10/10.4/10.4.1.4.2/Returns |
| N | 10/10.4/10.4.1.4.3/Rejections |
| N | 10/10.4/10.4.2/Denials |
| N | 10/10.4/10.4.2.1/Denials – General Principles |
| N | 10/10.4/10.4.2.2/Denial Reasons |
| N | 10/10.4/10.4.2.3/Additional Denial Policies |
| N | 10/10.4/10.4.3/Voluntary and Involuntary Terminations |
| N | 10/10.4/10.4.4/Changes of Information |
| N | 10/10.4/10.4.5/Revalidations |
| N | 10/10.4/10.4.5.1/Revalidation Solicitations |
| N | 10/10.4/10.4.5.2/Non-Responses to Revalidation and Extension Requests |
| N | 10/10.4/10.4.5.3/Receipt and Processing of Revalidation Applications |
| N | 10/10.4/10.4.6/Reactivations |

| R/N/D | CHAPTER / SECTION / SUBSECTION / TITLE |
|---|---|
| N | 10/10.4/10.4.7/Revocations |
| N | 10/10.4/10.4.7.1/Revocations – Background and General Requirements |
| N | 10/10.4/10.4.7.2/Revocation Effective Dates |
| N | 10/10.4/10.4.7.3/Revocation Reasons |
| N | 10/10.4/10.4.7.4/Reenrollment Bar |
| N | 10/10.4/10.4.7.5/Additional Revocation Policies |
| N | 10/10.4/10.4.8/Deactivations |
| N | 10/10.4/10.4.8.1/Deactivation Rebuttals |

**III. FUNDING:**

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

**IV. ATTACHMENTS:**

**Business Requirements**
**Manual Instruction**

# Attachment - Business Requirements

| Pub. 100-08 | Transmittal: 11020 | Date: October 1, 2021 | Change Request: 12412 |
|---|---|---|---|

**SUBJECT: Restructuring of Section 10.4 in Chapter 10 of Publication (Pub.) 100-08**

**EFFECTIVE DATE: October 29, 2021**
**Unless otherwise specified, the effective date is the date of service.*
**IMPLEMENTATION DATE: October 29, 2021**

## I. GENERAL INFORMATION

**A. Background:** This CR splits existing Section 10.4 in Chapter 10 of Pub. 100-08 into numerous subsections. This will better enable CMS to make future revisions to the instructions in Section 10.4. The changes in this CR are structural and organizational in nature. Any necessary policy changes or significant clarifications involving the instructions in Section 10.4 will be made via subsequent CRs.

**B. Policy:** This CR does not contain any legislative or regulatory policy changes.

## II. BUSINESS REQUIREMENTS TABLE

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

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | | FISS | MCS | VMS | CWF | |
| 12412.1 | The contractor shall observe the structural and organizational revisions to Section 10.4 in Chapter 10 of Pub. 100-08. | X | X | X | | | | | | |

## III. PROVIDER EDUCATION TABLE

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

## IV. SUPPORTING INFORMATION

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

*"Should" denotes a recommendation.*

| X-Ref Requirement Number | Recommendations or other supporting information: |
|---|---|

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

## V. CONTACTS

**Pre-Implementation Contact(s):** Frank Whelan, 410-786-1302 or frank.whelan@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. 11020; Issued: 10-01-21)***

## 10.2.3 - Individual Practitioners Who Enroll Via the Form CMS-*8*55I

***(Rev. 11020; Issued: 10-01-21; Effective: 10-29-21; Implementation: 10-29-21)***

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

It is important that contractors review Publication (Pub). 100-02, Medicare Benefit Policy Manual, chapter 15 and Pub. 100-04, Claims Processing Manual, for specific information regarding the required qualifications of the suppliers listed in this section 10.2.3 et seq.

## 10.4 – Medicare Enrollment: Contractor Processing Duties *and Related Policies*

***(Rev. 11020; Issued: 10-01-21; Effective: 10-29-21; Implementation: 10-29-21)***

### *10.4.1 – General Processing Functions*

***(Rev. 11020; Issued: 10-01-21; Effective: 10-29-21; Implementation: 10-29-21)***

*This section 10.4.1 et seq. outlines the general methods that contractors shall follow when processing enrollment applications. (More specific processing activities can be found elsewhere in this chapter (e.g., sections 10.3.1 et seq., 10.6.6, etc.)). Should an inconsistency or gap exist between the general procedures outlined in section 10.4.1 et seq. and those of greater specificity in other sections of this chapter, the latter shall take precedence unless otherwise noted. CMS stresses that nothing in this section 10.4.1 et seq. (except as stated to the contrary) supplants more detailed instructions in this chapter (or another CMS directive) pertaining to, for instance: (1) processing alternatives; (2) referrals to the state agency; (3) processing policies specific to certain CMS applications (e.g., CMS-855, CMS-20134) and certain sections thereof.*

*All references to "provider" include "supplier" unless stated otherwise.*

#### *10.4.1.1 – Overview of the Process*

***(Rev. 11020; Issued: 10-01-21; Effective: 10-29-21; Implementation: 10-29-21)***

***A. Typical Steps***

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

*1. Contractor receives application*

*2. Contractor reviews application and verifies data thereon*

*3. If (i) required data/documentation is missing, (ii) data cannot be verified, and/or (iii) there are data discrepancies, contractor requests missing/clarifying information from the provider.*

*4. If applicable, contractor (i) verifies any newly furnished data or (ii) seeks additional data/clarification from provider*

*5. Certain situations may require referral to the state agency (the state) and, after receiving information from the state, referral to CMS PEOG before a final determination is rendered.*

*6. Final determination*

*Section 10.4.1 et seq. is structured so as to generally follow the preceding six steps.*

***B. Non-Form CMS-855 and CMS- 20134 Documentation***

*There are situations where the contractor processes non-Form 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 (L & T) 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.*

## *10.4.1.2 – Receipt of Application*

***(Rev. 11020; Issued: 10-01-21; Effective: 10-29-21; Implementation: 10-29-21)***

### *A. Acknowledgment of Receipt of Application*

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

### *B. Pre-Screening of Application*

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

### *C. Reassignment Packages*

*In situations where an entity wants to simultaneously (i) enroll a group practice, (ii) enroll the individual practitioners therein, and (iii) reassign benefits accordingly, the instructions below apply. 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 contractor 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.*

*Only the Form CMS-855I is submitted in CAH situation - 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 Form CMS-855R if it is not submitted upon receipt and processing of the Form CMS-855I. Upon receipt of the Form CMS-855R, the contractor shall process the application and reassign the individual to the Part A entity.*

*Form CMS-855A and Form CMS-855B never submitted - 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.*

## *10.4.1.3 – Review of Application*

***(Rev. 11020; Issued: 10-01-21; Effective: 10-29-21; Implementation: 10-29-21)***

*Unless stated otherwise in this chapter or in another CMS directive, the instructions in this section 10.4.1.3 et seq. apply to:*

- *The Form CMS-855A, Form CMS-855B, Form CMS-855I, Form CMS-855R, Form CMS-855O, Form CMS-20134, and opt-out affidavits.*

- *All Form CMS-855, CMS-20134, and opt-out affidavit transaction types identified in this chapter (e.g., changes of information, reassignments).*

## *10.4.1.3.1 – Initial Steps of Review of Application*

***(Rev. 11020; Issued: 10-01-21; Effective: 10-29-21; Implementation: 10-29-21)***

### *A. Opening Review – Basic Activities*

*Except as stated otherwise in this chapter (see section 10.4.1 for more details) or when a processing alternative applies, the contractor shall undertake the following:*

*1. Confirmation of Completion - Ensure that the provider has completed all required data elements on the Form CMS-855, Form CMS-20134 or opt-out affidavit (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 Form CMS-20134. (The instructions on the Form CMS-855 or Form CMS-20134 shall be read and applied in addition to, and not in lieu of, the instructions in this chapter and all other applicable CMS directives.)*

*2. Verification - Verify and validate all information the provider furnished on the Form CMS-855, Form CMS-20134, or opt-out affidavit (assuming a data source is available).*

*3. State Agency - Coordinate with the state and/or SOG Location as needed.*

*4. Exclusion/Debarment - For initial enrollments, revalidations, 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 by the HHS OIG or through the System for Award Management.*

## *B. Paper Applications*

### *1. 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 the application fee) upon review. This includes but is not limited to:*

- *Ensuring that all required data elements on the application have been completed and that all required supporting documentation has been submitted*

- *Ensuring that the provider 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 (assuming that a data source is available)*

- *Entering into PECOS all information contained on the application.*

*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).*

### *2. Photocopying Pages*

*The contractor may accept photocopied pages in any Form CMS-855 or Form CMS-20134 it receives so long as the application contains 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.*

### *3. White-Out & Highlighting*

*The contractor shall not write on or highlight any part of the original Form CMS-855 or Form CMS-20134 application or any supplementary pages the applicant submits (e.g., copy of license). Provider usage of white-out is acceptable, although the contractor should contact the applicant to resolve any ambiguities. In addition, the contractor must determine whether the amount of white-out used on a particular application is within reason. For instance, if an entire application page is whited-out, the contractor should request that the page be resubmitted.*

## *C. Internet-Based PECOS Applications*

*(The contractor shall begin processing the application upon receipt and shall develop for missing certification statements and all other missing information, including the application fee (if applicable), upon review.)*

*1. Statuses - L & T statuses for PECOS Internet applications that are not in a final status are: (i) Received; (ii) In Review; (iii) Returned for Corrections; (iv) Corrections Received; (v) Review Complete; and (vi) Application in Process.*

*The submission of a PECOS Internet application will immediately place the L & T record into a "Received" status.*

*2. Certification Statement Policies*

*a. Early Return - If the contractor can determine (without having yet begun processing the application) that an application can be returned per this chapter 10 (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.*

*b. Submission Mechanism - The provider shall submit an e-signature or submit a certification statement via PECOS upload functionality. No paper certification statements shall be submitted via mail, fax, or scanned e-mail, unless stated otherwise in this chapter or in another CMS directive.*

*c. Invalid Certification Statement - 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.*

*d. Initial Applications and Authorized Officials - For initial PECOS Internet applications (as the term "initial" is defined in this chapter), it is necessary that all authorized officials provide dated signatures with the application.*

*e. Changes of Information and Signatures - For Internet-based PECOS changes of information (as the term "changes of information" is defined in 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 the procedures in 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."*

*After changing the L & T status to "In Review," the contractor shall review the Application Data Report (ADR) and 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. Transfer of Data into PECOS***

*Once the contractor ties the L & T record to the enrollment record, the contractor shall begin the process of transferring the data into PECOS by accepting or rejecting the various data elements. The contractor shall note that: (1) it cannot undo any transfer of information into PECOS; and (2) once the L & T is tied to the enrollment record, the application cannot be returned to the provider for corrections.*

### *F. Miscellaneous Instructions*

*1. 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."*

*2. Gatekeeper/Enrollment Screens - The Gatekeeper and Enrollment screens are only used in the case of Form CMS-855 or Form CMS-20134 initial enrollment PECOS Internet submissions.*

*3. 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 of this chapter.*

*4. State Agencies – Except as stated otherwise in this chapter, the contractor shall send to the state a copy of the ADR in lieu of the Form CMS-855 if the provider submitted its application via the Internet.*

*5. Possible Circumvention - If the contractor suspects that a provider 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 its PEOG BFL for guidance.*

*6. State and Country of Birth - The state of birth and country of birth are optional data elements on the Form CMS-855 and Form CMS-20134. As such, the contractor shall not (i) develop for this information if it was not disclosed on the application or (ii) request other contractors to update the PECOS Associate Control (PAC) ID to include this data.*

## *10.4.1.3.2 – Data Verification*

***(Rev. 11020; Issued: 10-01-21; Effective: 10-29-21; Implementation: 10-29-21)***

### *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, assuming 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 Form CMS-20134 is accurate.*

*Examples of verification techniques include, but are not limited to: (i) site visits; (ii) third-party data validation sources; (iii) state professional licensure and certification websites (e.g., medical board sites); (iv) federal licensure and certification websites (if applicable); (v) state business web sites (e.g., to validate "doing business as" name); and (vi) Yellow Pages (e.g., to verify certain phone numbers).*

*The list of verification techniques identified in this section 10.4.1.3.2 is not exhaustive. If the contractor is aware of another means of validation that is as cost-effective and accurate as those listed, it may use it. However, all SSNs and NPIs listed on the application shall 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. Overall Verification Principles*

*Unless stated otherwise in this chapter or in another CMS directive, the following 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: (i) concluding that the furnished data is accurate; or (ii) requesting clarifying information if the data element cannot be verified (though the contractor is encouraged to make a second attempt using a different validation means prior to requesting clarification).*

### *C. Concurrent Reviews*

*If the contractor receives multiple Form CMS-855 or Form CMS-20134s for related entities, it can perform concurrent reviews of similar data. For instance, suppose a chain home office submits initial Form CMS-855As for four of its chain providers. The ownership information (Sections 5 and 6) and chain home office data (Section 7) is the same for all four providers. The contractor need only verify the ownership and home office data once; it need not do so 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 another 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.*

### *E. Proof of Life Documentation*

*When 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). If the provider cannot obtain such documentation, the contractor shall submit a request to its PEOG BFL containing the provider's name, date of birth, and SSN so that CMS can confirm proof of life with SSA.*

## *10.4.1.3.3 – Requesting Missing/Clarifying Data/Documentation (Development)*

***(Rev. 11020; Issued: 10-01-21; Effective: 10-29-21; Implementation: 10-29-21)***

*This section 10.4.1.3.3 addresses the contractor's solicitation of missing/clarifying information/documentation and/or a valid certification statement. The policies herein apply except as otherwise stated in this chapter or another CMS directive.*

***A. Only One Request Needed***

*The contractor need only make one request. Of course, the contractor should 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.*

***B. Commencement of Timeframe***

*The provider has 30 calendar days to furnish the information or documentation the contractor requested. This 30-day clock 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.*

***C. 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:*

*1. 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.*

*2. When leaving a message, the contractor shall also state that the requested data/clarification must be furnished within 30 days.*

*3. Telephone requests shall be made on weekdays between 9 am and 5 pm of the provider's time zone.*

*4. The 30-day clock begins on the day (1) of the telephone conversation with the appropriate official, or (2) the message is left.*

***D. Inability to Contact Provider***

*If the contractor cannot, for the reasons listed in (i) through (iii) below, communicate with the provider to request information/documentation, it shall attempt one alternative means of communication:*

*(i) The mailed letter is returned because the provider is not at that address;*

*(ii) The contractor cannot e-mail the letter to the provider because of issues with the recipient's e-mail system; or*

*(iii) The provider's fax number is repeatedly busy*

*If an alternative communication, too, 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 the provider is 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.)*

***E. Development Reasons and Elements of Letter***

***1. Paper Applications***

*a. Reasons to Develop*

*Development is necessary if the provider or supplier: (i) submits an application with at least one missing required data element; (ii) fails to submit at least one required document; (iii) submits an invalid certification statement; (iv) writes "N/A" (or a variation thereof) in response to a question that requires a "yes" or "no" answer; or*
*(v) submits the full application via fax or e-mail unless the contractor has provided for an exception based on extenuating circumstances. (If the contractor instructs the provider to submit the application via fax or e-mail, the contractor shall inform its PEOG BFL.)*

*Development is also required 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 in section 10.4.1.3.3(E)(1)(a) 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 et seq. 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 submit 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. (This certification statement will cover both the submission of any missing data as well as any deficiencies associated with the original certification statement.) The provider may submit the certification statement via scanned e-mail, fax or mail (paper submissions only).*

*(A new certification statement is not required if the only missing material is documentation or if the requested clarification does not require any changes to the provider's Form CMS-855 or CMS-20134 application.)*

*iv. If missing data is involved, the contractor shall direct the provider 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 e-mail address may be included if applicable.*

*vi. The name and phone number of a contact person at the contractor site. An e-mail address may be included if applicable.*

***2. Internet-Based PECOS Applications***

*a. Reasons to Develop*

*Development is necessary if the provider or supplier: (i) submits an application with at least one missing required data element; (ii) fails to submit at least one required document; (iii) submits an invalid certification statement; or (iv) enters "N/A" (or a variation thereof) in response to a question that requires an answer.*

*b. Elements of a Development Request*

*When developing for more information (after switching the L & T status to "Returned for Corrections"), the contractor shall send a request to the provider 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.*

## *10.4.1.3.4 - Receiving Missing/Clarifying Data/Documentation (Response to Development)*

***(Rev. 11020; Issued: 10-01-21; Effective: 10-29-21; Implementation: 10-29-21)***

***A. Requirement to Furnish All Missing/Clarifying Material***

*The provider must furnish <u>all</u> missing/clarifying data/documentation the contractor requested within the 30-day timeframe. Whether the provider furnished all 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.*

***B. Format of Furnishing Missing Data***

***1. Paper Applications***

*Unless stated otherwise in this chapter or in another CMS directive, the provider shall: (1) provide the missing/clarification information (excluding documentation) on the applicable Form CMS-855 or 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 provider may submit the certification statement via scanned e-mail, fax or mail (paper submissions) along with the missing information.*

***2. Internet-Based PECOS Applications***

*Unless stated otherwise in this chapter or in another CMS directive, the provider may: (1) submit the missing information by entering it into PECOS; or (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 provider may submit the certification statement via scanned e-mail, fax, upload or e-signature along with the missing information.*

***C. Format of Clarifying Data***

*In cases where clarifying (as opposed to missing) information is requested, the contractor may accept the clarification by 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 requires the provider to change or alter data that must be reported on the paper Form CMS-855, CMS-20134, or PECOS application, the contractor shall instruct the provider (via a follow-up e-mail or fax) to (1) submit the revised data on the applicable paper CMS-855 or CMS-20134 or PECOS application and (2) 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 provider must submit the certification statement via scanned e-mail, 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 need not contact the provider for an accompanying written explanation. (This is because the clarification was furnished in writing via the Form 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 the provider submit a written explanation no later than March 31.*

***D. Maintenance of Received Material***

*The contractor shall maintain all missing/clarifying information or documentation received (including new certification statements) in the provider file. Storage can be electronic or via hard copy, but it must be in an otherwise easily accessible format.*

## *10.4.1.3.5 – Provider/Supplier Fails to Submit Requested Data/Documentation*

***(Rev. 11020; Issued: 10-01-21; Effective: 10-29-21; Implementation: 10-29-21)***

*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 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.*

## *10.4.1.4 – Application Disposition*

***(Rev. 11020; Issued: 10-01-21; Effective: 10-29-21; Implementation: 10-29-21)***

## *10.4.1.4.1 – Approvals*

***(Rev. 11020; Issued: 10-01-21; Effective: 10-29-21; Implementation: 10-29-21)***

*(This section 10.4.1.4.1 does not apply in situations where another CMS instruction contains alternative direction.)*

### *A. Non-Certified Suppliers and Individual Practitioners*

*(This section 10.4.1.4.1(A) 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 supplier via letter of the approval. The letter shall follow the content and format of the applicable model letter in section 10.7 et seq. of this chapter.*

*The contractor shall send the approval letter via e-mail, mail, or fax within 5 business days of approving the enrollment application in PECOS. (This timeframe should allow for updating the enrollment information in the shared systems (MCS, FISS or VMS)). For all applications other than the Form CMS-855S, the contractor shall send the letter 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.*

### *B. Certified Providers and Certified Suppliers*

*(This section 10.4.1.4.1(B) only applies to: (1) initial Form CMS-855A applications or CHOW, acquisition/merger, or consolidation applications submitted by the new owner; and (2) initial ambulatory surgical center and portable x-ray supplier applications. Note also that this subsection (B) contains only general instructions regarding certified provider/supplier approvals. Instructions in other chapter 10 sections (e.g., sections 10.2.1 et seq., 10.2.2 et seq., 10.6.1 et seq.) may contain more specific direction, such as with the processing of FQHC applications. Except as stated otherwise, these more specific instructions take precedence over those in this section 10.4.1.4.1(B)).*

*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 SOG Location. The recommendation letter shall follow the guidance and format of the applicable template letter in section 10.7 et seq. of this chapter. The contractor may also include an explanation of any special circumstances, findings, or other information that the state should know about. The letter can be sent to the state/SOG Location via mail, fax, or e-mail.*

*Also, the contractor:*

*(i) Shall 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 SOG Location, 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 Form CMS-855, associated documentation, and recommendation letter are mailed, they should be included in the same package.*

*(ii) Shall not send a copy of the Form CMS-855 to the SOG Location unless the latter specifically requests it or if the transaction in question is one for which state involvement is unnecessary.*

*(iii) 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.*

### *C. DMEPOS Suppliers*

*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: (i) the supplier has submitted a complete Form CMS-855S (including all supporting documentation, to the National Supplier Clearinghouse (NSC)); and (ii) the item was furnished on or after the date the NSC issued to the supplier a DMEPOS supplier number conveying Medicare billing privileges.*

### *D. 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 because some MDPP suppliers may not begin furnishing services until receiving such information.*

*If the contractor approves an MDPP supplier's enrollment, it shall notify the supplier via letter of the approval. The letter shall follow the content and format of the applicable model letter in section 10.7 et seq. of this chapter.*

*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'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 successful enrollment.*

### *E. Additional Copies of Approval Letters*

*With the exception of Form CMS-855S applications, if any contact person listed on a provider/supplier's enrollment record requests a copy of the provider/supplier's Medicare approval letter, the contractor shall send it to the contact person via e-mail, fax, or mail. (This excludes certification letters or tie-in notices), for the contractor does not generate 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.*

## *10.4.1.4.2 - Returns*

***(Rev. 11020; Issued: 10-01-21; Effective: 10-29-21; Implementation: 10-29-21)***

### *A. Reasons/Grounds for Return*

*Unless stated otherwise in this chapter or in another CMS directive, the contractor (including the NSC) may immediately return the enrollment application to the provider 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, etc.):*

*(i) The provider/supplier 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).*

*(ii) The contractor received the Form CMS-855 or CMS-20134 application more than 60 days prior to the effective date listed on the application.*

*(iii) 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.)*

*(iv) The contractor can confirm that the provider/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*

*(v) The provider/supplier submitted an initial application prior to the expiration of a reenrollment bar or reapplication bar.*

*(vi) The application is to be returned per the instructions in section 10.6.1.1.3.1.1 of this chapter.*

*(vii) 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. Since 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, for the physician is already enrolled via the Form CMS-855I.*

*(viii) The provider/supplier submitted a revalidation application more than seven months prior to their revalidation due date.*

*(ix) The MDPP supplier submitted an application with a coach start date more than 30 days in the future.*

*(x) A provider/supplier requests that their application be withdrawn prior to or during processing.*

*(xi) A provider/supplier submits an application that is an exact duplicate of an application that has been processed previously or one that is currently pending processing.*

*(xii) A provider/supplier submits a paper Form CMS-855 or CMS-20134 application that is outdated (i.e., a physician submits a Form CMS-855I application that was approved for use in 07/11; because this form was replaced with the 12/18 version, the 07/11 version shall be returned).*

*(xiii) A rebuttal decision has been issued (therefore, the submitted Form CMS-855, CMS-588, or CMS-20134 is not needed).*

*(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.)*

*Note that 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 the provider already submitted an application fee, the contractor shall follow existing instructions regarding the return of the fee.*

***B. Procedures for Returning the Application***

*If the contractor returns the application, the following apply:*

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

*(ii) The contractor shall not enter the application into PECOS. No L & T record shall be created.*

*(iii) 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.)*

*(iv) The contractor shall: (A) keep the original application and supporting documents and return a copy; (B) make a copy or scan of the application and documents and return the originals to the provider; or (C) 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. Special Situations Concerning Changes of Information and Changes of Ownership***

*1. <u>Expiration of Timeframe for Reporting Changes</u> - 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 expired, the contractor shall send an e-mail to its PEOG BFL notifying him or her of the return. PEOG will determine whether the provider/supplier's Medicare billing privileges should be deactivated or revoked and will notify the contractor of its decision.*

*2. <u>Timeframe Not Yet Expired</u> - 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 referenced in section 10.4.1.4.2(C)(1) after the expiration of said time period unless the provider has resubmitted the change request/CHOW.*

*3. <u>Second Return, Rejection, or Denial</u> – If, per section 10.4.1.4.2, the provider resubmits the change of information or CHOW application and the contractor either returns it again, rejects it, or denies it, the contractor shall send the e-mail referenced in section 10.4.1.4.2(C)(1) regardless of whether the applicable timeframe has expired. PEOG will determine whether the provider/supplier's Medicare billing privileges should be deactivated or revoked and will notify the contractor of its decision.*

### *D. Reactivations*

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

### *E. Revalidations*

*If the contractor returns a revalidation application, the contractor shall – unless an existing CMS instruction or directive states 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 indeed resubmits the application and the contractor returns it again, rejects it, or denies it, the contractor shall – absent another CMS instruction to the contrary - deactivate the provider's billing privileges, assuming the applicable time period has expired.*

## *10.4.1.4.3 - Rejections*

***(Rev. 11020; Issued: 10-01-21; Effective: 10-29-21; Implementation: 10-29-21)***

### *A. Background*

*In accordance with 42 CFR § 424.525(a)(1) and (2), the contractor (including the NSC) 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 where 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 PECOS certification statement: (a) is unsigned; (b) is undated; (c) contains a copied or stamped signature; (d) was signed (as reflected by the date of signature) more than 120 days prior to the date on which the contractor received the application); (e) is missing; or (f) for paper Form CMS-855I and Form CMS-855O submissions, was signed by someone other than the physician or non-physician practitioner.*

*(ii) The provider/supplier 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 incorrect application was submitted (e.g., a Form CMS-855B was submitted for Part A enrollment)*

*(v) The provider/supplier submitted its application or Internet-based PECOS certification statement via fax or e-mail when it was not otherwise permitted to do so*

*(vi) The provider/supplier failed to submit a required application fee*

*The applications described in (i) through (vi) above shall be developed, rather than returned. For instance, if a 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 § 424.525(a) starts on the date the contractor mails, faxes, or e-mails the development letter or other request for information to the provider. If the contractor makes a follow-up request for information, the 30-day clock does not start anew; rather, it keeps running from the date the development letter was sent. However, the contractor has the discretion to extend the 30-day timeframe if it determines that the provider 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 information, 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:*

*EXAMPLE: A 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, applicable body, and resolution data fields remains blank. The contractor need not make a second request for this data to be furnished. It can reject the application on March 31, or 30 days after its initial request was made.*

***D. Creation of 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 can create an L & T record for a rejected application, it shall flip the status to "rejected" in PECOS.*

***E. Other Impacts of a Rejection***

***1. Changes of Information and CHOWs***

*a. <u>Expiration of Timeframe for Reporting Changes</u> - If the contractor rejects a change of information or CHOW submission per this chapter and the applicable 90-day or 30-day period for reporting the change has expired, the contractor shall send an e-mail to its PEOG BFL notifying him or her of the rejection. PEOG will determine whether the provider/supplier's Medicare billing privileges should be deactivated or revoked and will notify the contractor of its decision.*

*b. <u>Timeframe Not Yet Expired</u> - 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 referenced in subsection (E)(1)(a) above after the expiration of said time period unless the provider/supplier has resubmitted the change request/CHOW.*

*c. <u>Second Rejection, Return, or Denial</u> – If, per subsection (E)(1)(b) above, the provider resubmits the change of information or CHOW application and the contractor either rejects it again, returns it, or denies it, the contractor shall send the e-mail referenced in subsection (E)(1)(a) above regardless of whether the applicable timeframe has expired. PEOG will determine whether the provider's Medicare billing privileges should be deactivated or revoked and will notify the contractor of its decision.*

### *F. Reactivations*

*If the contractor rejects a reactivation application, the provider's Medicare billing privileges shall remain deactivated.*

### *G. Revalidations*

*If the contractor rejects a revalidation application per this chapter 10, the contractor shall – unless an existing CMS instruction or directive states otherwise - deactivate the provider/supplier'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/supplier's billing privileges after the applicable time period expires unless the provider/supplier has resubmitted the revalidation application. If the provider/supplier indeed resubmits the application and the contractor rejects it again, returns it, or denies it, the contractor shall – absent a CMS instruction to the contrary - deactivate the provider's billing privileges, assuming the applicable time period has expired.*

### *H. Additional Rejection Policies*

#### *1. Resubmission after Rejection*

*If the provider's application is rejected, the provider must complete and submit a new Form CMS-855 or CMS-20134 (either via paper or Internet-based PECOS) and all necessary documentation.*

#### *2. Applicability*

*Unless stated otherwise in this chapter or another CMS directive, this section 10.4.1.4.3 applies to all applications identified in this chapter (e.g., initial applications, change requests, Form CMS-855O applications, Form CMS-588 submissions, CHOW applications, revalidations, and reactivations).*

#### *3. 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.*

#### *4. 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 no later than 5 business days after the contractor concludes that the provider's application should be rejected.*

#### *5. Copy of Application*

*If the contractor rejects an application, it shall either (1) keep the original application and all supporting documents or (2) make a copy or scan of the application and documents and return the originals to the provider. If the contractor chooses the former approach and the provider requests a copy of its application, the contractor may fax or mail it to the provider.*

## *10.4.2 - Denials*
***(Rev. 11020; Issued: 10-01-21; Effective: 10-29-21; Implementation: 10-29-21)***

*In executing the instructions in section 10.4.2 et seq. of this chapter, the contractor shall also adhere to:*

*(i) The supplemental and superseding instructions in section 10.6.6 of this chapter concerning final adverse actions (e.g., referrals to PEOG);*

*(ii) The letter formats and verbiage in section 10.7 et seq. of this chapter; and*

*(iii) Any other directive that, per CMS, explicitly pre-empts any instruction(s) in section 10.4.2 et seq. of this chapter.*

*If any instruction in categories (i) through (iii) above conflict with that in section 10.4.2 et seq., the instruction in (i), (ii), or (iii) applies. In addition, the contractor shall adhere to any instruction in (i), (ii), or (iii) above that addresses a denial-related matter not discussed in section 10.4.2 et seq.*

## *10.4.2.1 - Denials – General Principles*
***(Rev. 11020; Issued: 10-01-21; Effective: 10-29-21; Implementation: 10-29-21)***

### *A. Notification Letters for Denials*

*If the contractor finds a legal basis for denying an application - and, if applicable under section 10.4.2 et seq., section 10.6.6, or another CMS directive, receives approval from PEOG for said denial - the contractor shall deny the application and notify the provider by letter. Except as stated otherwise in this chapter, the denial letter shall contain:*

*(i) A legal (i.e., regulatory) basis for each reason for the denial;*

*(ii) A clear explanation of why the application is being denied, including the facts or evidence that the contractor used in making its determination;*

*(iii) An explanation of why the provider does not meet the applicable enrollment criteria;*

*(iv) The appropriate regulatory basis (e.g., 42 CFR § 424.530(a)(1)) for the denial. (The contractor shall not use provisions from this chapter 10 as the basis for denial.)*

*(v) Procedures for submitting a corrective action plan (CAP, for denials based on 42 CFR § 424.530(a)(1)); and*

*(vi) Complete and accurate information about the provider's further appeal rights.*

*In addition, the letter shall follow the format of the applicable model denial letter in section 10.7 et seq. of this chapter.*

*There is no reenrollment bar for denied applications. Reenrollment bars apply only to revocations.*

### *B. When Prior PEOG Approval of the Denial Necessary*

*For cases involving 42 CFR § 424.530(a)(3) (Felony Convictions), § 424.530(a)(4) (False or Misleading Information or Application), § 424.530(a)(6) (Existing Overpayment at Time of Application), § 424.530(a)(12) (Revoked Under Different Name, Numerical Identifier, or*

*Business Identity), § 424.530(a)(13) (Affiliation that Poses an Undue Risk), § 424.530(a)(14) (Other Program Termination or Suspension), and 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. The contractor shall also obtain prior PEOG approval of the denial and denial letter if otherwise required to do so in this chapter or another CMS directive (i.e., certain denial situations other than those described in this subsection 10.4.2.1(B) require prior PEOG approval).*

*PEOG will notify the contractor of its determination (including, as applicable, whether a reapplication bar under § 424.530(f) is to be imposed) and instruct the contractor as to how to proceed. Absent a CMS instruction or directive to the contrary, the denial letter shall be sent to the provider via certified mail no later than 5 business days after PEOG concludes that the provider's application should be denied. The contractor shall not proceed with finalizing the denial until it receives the aforementioned guidance from PEOG. If this guidance is delayed, the contractor shall carve the impacted application(s) out of its timeliness reporting; the contractor shall document and report the impacted application(s) in its Monthly Status Reports.*

***C. When Prior PEOG Approval of the Denial Unnecessary – Timeframe for Sending Letter***

*Absent a CMS instruction or directive to the contrary, the denial letter shall be sent to the provider/supplier via certified mail no later than 5 business days after the contractor determines that the provider's application should be denied.*

***D. No Denial Recommendation to State***

*If the applicant is a certified provider or certified supplier and a denial reason is implicated, the contractor need not submit a recommendation for denial to the state/SOG Location. Except as stated otherwise in this chapter, the contractor can simply: (1) deny the application (though, as explained in this chapter, some denials might require prior PEOG approval); (2) close out the PECOS record; (3) send a denial letter to the provider; and (4) copy the state and the SOG Location on said letter.*

***E. PECOS Entry***

*All denied applications and all applicable denial reasons shall be entered into PECOS, including fingerprint and non-covered provider or supplier type denials. For non-covered provider or supplier type denials, the contractor shall select the "Other" specialty/provider/supplier type option and input the type listed on the application.*

## *10.4.2.2 - Denial Reasons*

***(Rev. 11020; Issued: 10-01-21; Effective: 10-29-21; Implementation: 10-29-21)***

***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 10.2.8 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 10.2.8 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) with which the provider/supplier is non-compliant.*

***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 Form CMS-855 or CMS-20134 is—*

*(i) 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*

*(ii) 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:*

*(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 outlined in section 1128 of the Social Security Act."*

*While a reenrollment bar is established for revoked providers/suppliers, this does not preclude the contractor from denying reenrollment to a provider/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 meets the above felony requirements, this would not itself warrant a denial of the MDPP supplier under § 424.535(a)(3). This is because the coach, not the MDPP supplier, has the felony conviction. The MDPP supplier could, however, be denied enrollment under § 424.530(a)(1) (non-compliance with enrollment requirements) for having an ineligible coach.*

*As explained in section 10.6.6 of this chapter, the contractor shall submit all felonies found on Form CMS-855 and CMS-20134 applications to PEOG for review via ProviderEnrollmentRevocations@cms.hhs.gov. (See section 10.6.6 for more information.)*

***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))***

***1. Background***

*Consistent with 42 CFR § 424.530(a)(6), an enrollment application may be denied if the provider, supplier, or owner thereof has an existing Medicare overpayment that is equal to or*

*exceeds a threshold of $1,500 and has not been repaid in full at the time the application was filed. More 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."*

*In addition, 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: (1) satisfies the criteria set forth in § 401.607 and agrees to a CMS-approved extended repayment schedule for the entire outstanding Medicare debt; or (2) repays the debt in full.*

### *2. Contractor's Determination of Overpayment*

*When processing a Form CMS-855A, CMS-855B, CMS-855I, CMS-855S, or CMS-20134 initial or change of ownership application (if applicable), the contractor shall determine – using a system generated monthly listing – whether the provider, supplier, or any owner listed in Section 5 or 6 of the application has an existing or delinquent Medicare overpayment, as described in section 10.4.2.2(F)(1) above and § 424.530(a)(6). If such an overpayment exists, the contractor shall deny the application, using 42 CFR §424.530(a)(6) as the basis. However, prior PEOG approval 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.*

### *3. Examples*

*Example #1: Dr. X, a sole proprietor, has a $70,000 overpayment. Three months later, he joins Group Y and becomes a 50 percent owner thereof. Group Y submits an initial*

*enrollment application two months thereafter. Group Y's enrollment could be denied because Dr. X is an owner.*

*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 still warranted because he is an owner of the enrolling supplier and 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.*

*In each of these examples, however, denial could be avoided if (1) the party with the overpayment is on a Medicare-approved plan of repayment or (2) the overpayments in question are currently being offset or being appealed.*

***4. Additional Considerations Involving § 424.530(a)(6)***

*The contractor shall also observe the following with respect to § 424.530(a)(6):*

*a. 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.*

*b. The instructions in this section 10.4.2.2(F) apply only to (i) initial enrollments and (ii) new owners in a change of ownership.*

*c. The term "owner" under § 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.*

*d. 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 10.4.2.2(F), the contractor shall not deny the application based on § 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 is currently 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 § 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 reenrollment bar period has not expired. In making its determination, CMS considers the following factors:*

*(i) Owning and managing employees and organizations (regardless of whether they have been disclosed on the Form CMS-855 [or CMS-20134] application);*
*(ii) Geographic location;*
*(iii) Provider or supplier type;*
*(iv) Business structure; or*
*(v) Any evidence indicating that the two parties [the revoked provider/supplier and the newly-enrolling provider/supplier] are similar or that the provider or supplier was created to circumvent the revocation or reenrollment 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 any of the following:*

*(i) A 5 percent or greater direct or indirect ownership interest that an individual or entity has in another organization.*
*(ii) A general or limited partnership interest (regardless of the percentage) that an individual or entity has in another organization.*
*(iii) 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.*
*(iv) An interest in which an individual is acting as an officer or director of a corporation.*
*(v) 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)***

*"(1) 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 (2) 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 under § 424.530(a)(14) is appropriate, CMS considers the following factors:*

*a. The reason(s) for the termination, suspension, or revocation;*

*b. 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*

*c. 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.*

***O. Denial Reason 15 (42 CFR § 424.530(a)(15) – Patient Harm)***

*"The physician or other 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 denial is appropriate, CMS considers the following factors:*

*(A) The nature of the patient harm*

*(B) The nature of the physician's or other eligible professional's conduct*

*(C) The number and type(s) of sanctions or disciplinary actions that have been imposed against the physician or other eligible professional by a 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: (i) license restriction(s) pertaining to certain procedures or practices; (ii) required compliance appearances before state oversight board members; (iii) 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); (iv) administrative/monetary penalties; and (v) formal reprimand(s).*

*(D) If applicable, the nature of the IRO determination(s).*

*(E) The number of patients impacted by the physician's or other eligible professional's conduct and the degree of harm thereto or impact upon."*

*Section 424.530(a)(15) does not apply to actions or orders pertaining exclusively to either of the following: (i) required participation in rehabilitation or mental/behavioral health programs; or (ii) required abstinence from drugs or alcohol and random drug testing.*

*NOTE: With respect to (a)(15), PEOG -- rather than the contractor – will make all determinations regarding whether this provision applies.*

## *10.4.2.3 – Additional Denial Policies*

***(Rev. 11020; Issued: 10-01-21; Effective: 10-29-21; Implementation: 10-29-21)***

### *A. Post-Denial Submission of Enrollment Application*

*A denied provider may not submit a new enrollment application until:*

*(i) If the initial denial was not appealed, the provider's appeal rights have lapsed;*

*(ii) If the initial denial was appealed, the provider has received notification that the determination was upheld; or*

*(iii) The reapplication bar has expired, if applicable.*

*The contractor shall return an application submitted before the aforementioned have occurred.*

### *B. 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.*

### *C. Denials - Changes of Information and Changes of Ownership (CHOWs)*

#### *1. Expiration of Timeframe for Reporting Changes*

*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 expired, the contractor shall send an e-mail to the CMS MedicareProviderEnrollment@cms.hhs.gov mailbox notifying PEOG of the denial. PEOG will determine whether the provider's Medicare billing privileges should be deactivated or revoked and will notify the contractor of its decision.*

#### *2. 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 referenced in subsection (C)(1) above after the expiration of said time period unless the provider has resubmitted the change request/CHOW.*

#### *3. Second Rejection, Return, or Denial*

*If, per subsection (C)(2) above, the provider resubmits the change of information or CHOW application and the contractor either denies it again, returns it, or rejects it, the contractor shall send the e-mail referenced in subsection (C)(1) above regardless of whether the applicable timeframe has expired. PEOG will determine whether the provider's Medicare billing privileges should be deactivated or revoked and will notify the contractor of its decision.*

### *D. Reactivations*

*If the contractor denies a reactivation application, the provider's Medicare billing privileges shall remain deactivated or revoked.*

### *E. Revalidations*

*If the contractor denies a revalidation application, the contractor shall – unless an existing CMS instruction or directive states 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 deactivate the provider's billing privileges after the applicable time period expires unless the provider has resubmitted the revalidation application. If, per the previous sentence, the provider resubmits the application and the contractor denies it again, returns it, or rejects it, the contractor shall - unless an existing CMS instruction or directive states otherwise – revoke the provider's billing privileges, assuming the applicable time period has expired.*

### *F. Appeals of Denials*

*For information regarding the provider enrollment appeals process, see section 10.6.18 of this chapter.*

## *10.4.3 – Voluntary and Involuntary Terminations*
***(Rev. 11020; Issued: 10-01-21; Effective: 10-29-21; Implementation: 10-29-21)***

### *A. Voluntary Terminations of Certified Providers and Certified Suppliers*

*For information regarding certified provider/supplier voluntary terminations, see section 10.6.1.3 of this chapter.*

### *B. Voluntary Terminations of Non-Certified Suppliers*

*The contractor shall adhere to the following when processing voluntary terminations of non-certified suppliers.*

*1. Timeframes – The contractor shall process such voluntary terminations in accordance with the timeframes in section 10.5 et seq. of this chapter.*

*2. Submission – Non-certified suppliers may only submit voluntary termination requests via the paper or Internet-based Form CMS-855/20134. They cannot do so via letter.*

*3. Reassignments/PTANs - 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.*

*When processing a voluntary termination of a reassignment, the contractor shall terminate non-certified suppliers effective the day after that which the supplier requested on its termination application.*

*4. Special Payments - Upon receipt of a non-certified supplier voluntary termination request, the contractor may ask the supplier to complete the "Special Payments" portion of Section 4 of the Form CMS-855/20134 so that future payments can be sent thereto. If the 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 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 supplier is not required to submit a Form CMS-588 in conjunction with a termination.*

### *C. Involuntary Terminations – Certified Providers/Suppliers*

*In the event an instruction in section 10.6.1 et seq. of this chapter contradicts guidance in this section 10.4.3(C), the section 10.6.1 et seq. guidance takes precedence.*

#### *1. Notification from State or SOG Location*

*If the contractor receives a notice from the state or SOG Location that involuntarily terminates a certified provider/supplier's Medicare participation because the provider/supplier no longer meets the conditions of participation, the contractor need not send a letter to the provider/supplier stating that its Medicare participation has been terminated. The state or SOG Location will issue such a letter and afford appeal rights. The contractor shall follow the applicable instructions in section 10.4.7 et seq. of this chapter with respect to revoking the provider/supplier's enrollment, since the provider/supplier is no longer compliant with Medicare enrollment regulations.* ***(NOTE:*** *The contractor must*

*identify in its revocation letter the exact provision within said statute(s)/regulation(s) with which the provider/supplier is non-compliant.)*

*The contractor shall record the revocation in PECOS using the status reason of "Non-Compliance: Provider/Supplier Type Requirements Not Met." The contractor shall not identify the involuntary termination action in PECOS as a Deactivation with a status reason of "Voluntarily Withdrawal from the Medicare Program." In addition, the contractor shall end-date the entity's enrollment record in PECOS in the same manner as it would upon receipt of a termination notice from the SOG Location.*

### *2. Revocation Letter*

*Per subsection (C)(1) above, the contractor shall issue a revocation letter to the certified provider/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 reenrollment bar as determined by CMS and indicated to the contractor. (See section 10.7 et seq. of this chapter for the applicable revocation letter.) The contractor shall e-mail a copy of the letter to the SOG Location using the same e-mail address it normally uses when communicating with the SOG Location's survey and certification staff.*

### *3. 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)*

## *10.4.4 – Changes of Information*

***(Rev. 11020; Issued: 10-01-21; Effective: 10-29-21; Implementation: 10-29-21)***

### *A. General Information*

*Unless as stated otherwise in this chapter, the following apply:*

*(i) The instructions in this section 10.4.4 apply to Part A and Part B enrollments.*

*(ii) In the event an instruction in section 10.6.1 et seq. of this chapter contradicts that in this section 10.4.4, the section 10.6.1 et seq. guidance takes precedence (e.g., certified provider/supplier change of information instructions in section 10.6.1.2 of this chapter).*

*(iii) Except as otherwise specified in this chapter or another CMS directive, if an enrolled provider/supplier 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 impermissible.) The provider/supplier shall: (a) furnish the changed data in the applicable section(s) of the form; and (b) sign and date the certification statement.*

*(iv) The timeframes for reporting changes are generally addressed in § 424.516.*

### *B. Time Requirements to Report Changes of Information via a Form CMS-855/20134 Application*

*1. Physicians/Non-Physicians/Groups*

*Pursuant to § 424.516(d), change of information requirements apply to physicians, non-physician practitioners, and physician and non-physician practitioner organizations (i.e., clinic/group practices). These supplier types must report the following changes within 30 days: (1) a change of ownership; (2) adverse legal action; and (3) a change in practice location. All other changes must be reported within 90 days.*

*2. DMEPOS Suppliers*

*Per 42 CFR §§ 424.57(c)(2) and 424.516(c), DMEPOS suppliers must report any change to their enrollment information within 30 days.*

*3. IDTFs*

*Per 42 CFR §§ 410.33(g)(2) and 424.516(b), IDTFs must report any change in adverse legal actions, ownership, location, and general supervision within 30 days. All other changes must be reported within 90 days.*

*4. MDPP Suppliers*

*Per 42 CFR §§ 424.205(d)(5) and 424.516(e), an MDPP supplier must update its enrollment application within 30 days of any change of ownership, change to its coach roster (including due to coach ineligibility or because the coach is no longer an employee, contractor, or volunteer of the MDPP supplier), or change in final adverse action history. All other changes must be reported within 90 days.*

*5. All Other Provider/Supplier Types*

*Consistent with 42 CFR § 424.516(e), all other provider/supplier types not specifically referenced in § 424.516(b) through (e) are subject to the following reporting timeframes:*

*(i) Changes of ownership or control (including changes in authorized official(s) or delegated official(s)) – 30 days*

*(ii) All other changes – 90 days*

*(In addition, and per § 424.516(e)(3), an air ambulance supplier must report a revocation or suspension of its license or certification to the contractor within 30 days of the revocation/suspension. The following FAA certifications must be reported: (a) specific pilot certifications including, but not limited to, instrument and medical certifications; and (b) airworthiness certification.)*

***C. Signatories and Notifications***

*1. Signer Not on Record - 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/supplier already has a Form CMS-855/20134 on file.) The contractor shall conduct all required validations concerning the individual.*

*2. Notifications – For changes of information that do not require state agency or SOG Location 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/B certified provider/supplier changes), the contractor shall:*

*(i) Furnish written, e-mail, or fax confirmation to the provider that the change has been made; and*

*(ii) Document the provider file (per section 10.6.19 of this chapter) with the date and time the confirmation was made. If, however, the transaction only involves an area code/ZIP code change, the contractor need not send confirmation to the provider that it has processed the change.*

*3. Confirmation of 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 PECOS or MCS to verify that the provider/supplier is no longer there and did in fact move.*

***D. Change in Special Payments Address***

*If the provider/supplier submits a change to its special payments address, the contractor shall verify the change by contacting the individual physician/practitioner (Form CMS-855I changes), an authorized or delegated official (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). 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 application, the contractor shall (unless another CMS directive instructs otherwise) follow the instructions in sections 10.4.4(D) and 10.4.4(C)(3) above, respectively, if the practice location address or special payment address on the application is different from that currently associated with the provider in PECOS or MCS.*

***E. Provider or Supplier Changing Specialty Type***

*With the exception of individual physicians, providers and suppliers (including non-physician practitioners) who wish to change their enrolled provider/supplier type must terminate their current enrollment and submit an initial enrollment application (Screening and an application fee (if applicable) applies for the new enrollment.)*

***F. Changes Involving 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 PECOS. (For purposes of this requirement, the term "change request" includes EFT changes.) It is immaterial whether: (1) 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 consistent 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 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 10.4.1.4.3 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:*

*(i) Processing the complete application consistent with the timeframes for initial applications outlined in this chapter.*

*(ii) Validate all data elements on the Form CMS-855 or CMS-20134 consistent with the instructions in this chapter pertaining to initial applications. The contractor shall not approve the change request until it has verified all data on the complete Form CMS-855 or CMS-20134.*

*(iii) 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.*

### *G. Incomplete or Unverifiable Changes of Information*

*(The contractor shall follow the instructions in this section 10.4.4(G) if it cannot process the submitted change request to completion.)*

*There can be instances where a provider has an enrollment record in PECOS and submits a change request but: (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 in these situations shall reject the change request in accordance with section 10.4.1.4.3 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 PEOG BFL for guidance. Examples include but are not limited to: (i) change in the provider's lone practice location; (ii) change in ownership; or (iii) change in EFT information.*

### *H. 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. 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.*

### *I. Special Instructions for Certified Providers, ASCs, and Portable X-ray Suppliers*

#### *1. Timeframe for State Review*

*In situations where state review of the change of information is required (see section 10.6.1.2), the contractor may (via any means) advise the provider that it may take several months for the request to be approved.*

***2. Post-Recommendation Changes***

*If an applicant submits a change request after the contractor recommends approval of the provider's initial Form CMS-855 application but before the state or SOG Location (as applicable) notifies the contractor that, respectively, it recommends approval of or approves the initial application, the contractor shall process the newly-submitted data as a separate change of information. The contractor shall not take the changed information/corrected pages and, immediately upon receipt, send them directly to the state/SOG Location for incorporation into the existing application. However, the contractor need not enter the change request into PECOS until it receives the aforementioned state or SOG Location (as applicable) approval/recommendation thereof.*

*In entering the change request into PECOS, the contractor shall use the date on which it received the change request in its mailroom as the actual receipt date in PECOS; the contractor shall not use the date on which the contractor received the aforementioned state/SOG Location approval/recommendation. The contractor shall explain the situation in the "Comments" section in PECOS and in the provider file.*

***J. Critical Access Hospital (CAH) Addition of New Provider-Based Locations***

*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 contractor shall contact the appropriate SOG Location while processing the Form CMS-855A to verify 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 contractor may not make a recommendation for approval without receiving a response from the SOG Location.*

*If the SOG Location finds that CAH's new provider-based location meets the distance requirements, the contractor shall continue processing the application normally. If the SOG Location determines that the location does not meet the distance requirements, the contractor shall reject the application and issue to the CAH the applicable rejection letter outlined in section 10.7 et seq.*

*The SOG Location will provide the CAH with three options if the location 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 Pub. 100-07, chapter 3, section 3012).*
*2. The CAH terminates the new provider-based location and continue its enrollment as a CAH.*
*3. The CAH keeps the new provider-based location but converts to a hospital (as outlined in Pub. 100-07, chapter 2, sections 2256G and 2256H).*

*For each option, the contractor shall keep the CAH's enrollment in an approved status in PECOS. For Option #1 above, the contractor will receive notice from the SOG Location of the termination, which will lead to revocation of the CAH's enrollment. For Option #2, the CAH's enrollment remains approved and the contractor shall expect no further communication from the SOG Location. If the CAH chooses Option #3 to convert to a*

*hospital, the contractor will receive a Form CMS-855A to terminate the CAH's enrollment and a new Form CMS-855A to enroll as a hospital.*

## *10.4.5 – Revalidations*

***(Rev. 11020; Issued: 10-01-21; Effective: 10-29-21; Implementation: 10-29-21)***

*Except as otherwise stated in this chapter or another CMS directive, the contractor shall follow the guidance in sections 10.4.5 through 10.4.5.3 of this chapter when processing revalidation applications. This guidance takes precedence over all other instructions in this chapter concerning 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 DMEPOS suppliers). However, CMS reserves the right to perform off-cycle revalidations as deemed necessary.*

## *10.4.5.1 – Revalidation Solicitations*

***(Rev. 11020; Issued: 10-01-21; Effective: 10-29-21; Implementation: 10-29-21)***

### *A. Revalidation Lists*

*1. Background*

*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 aforementioned lists will contain a suggested revalidation due date (month and day of the year) to assist contractors in staggering their workload and distributing the e-mails or mailings evenly. The contractor shall review the list and may alter a provider's due date month based on staffing levels and workload. However, the date by which the revalidation is due shall always be the last day of each month (i.e., June 30, July 31, or August 31). When distributing the workload, the contractor shall ensure that the revalidation due dates are divided equally over a 7 month period and account 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). The contractor shall also ensure that the due dates selected do not go beyond the current year.*

*Once CMS receives the contractor-confirmed lists, a final list will be generated capturing the provider's due date and timeframes for each revalidation action (i.e., e-mail or mail date, pend, deactivation). The list will be: (1) posted to the CGI Share Point Ensemble site; and (2) refreshed with updated enrollment data every 60 days to account for deactivated providers as well as providers that have had changes in their enrollment information. The contractor shall use the most current list available to conduct its e-mails or mailings and shall allow sufficient time for the provider to meet its deadline (between 90 to 105 days prior to the revalidation due date).*

*This list will be available on https://data.cms.gov/revalidation so that providers are aware of those selected for revalidation.*

*2. Additional Listing Information*

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

*3. Large Group Revalidation Coordination*

*Along with providing the finalized revalidation list with contractor-confirmed due dates, CMS will furnish 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. The contractor may stagger the large group mailings as it sees fit to ensure that the group receives notification that providers within their group will receive a request to revalidate in the next 7 months. The contractor shall send the notification letter to the authorized/delegated official or the enrollment contact person. The contractor may send the group notices via e-mail utilizing the e-mail addresses provided as part of the CMS list (derived from Section 2 and 13 of PECOS).*

*The contractor shall indicate **"IMPORTANT: Group Notification of Upcoming Provider Enrollment Revalidation Request"** in the subject line to differentiate this from other e-mails. The contractor shall use the applicable large group revalidation letter in section 10.7 et seq. of this chapter as notification to the large groups. The letter: (1) shall be attached in the body of the e-mail; and (2) should not be included as an attachment to the e-mail or require that a password be sent to the provider to view the e-mail content. (Except as stated in the following paragraph, the contractor need not send a paper copy of the group notice if sent via e-mail.)*

*If all of the aforementioned e-mails are returned as undeliverable, the contractor shall mail paper revalidation notices to the provider's correspondence and special payment addresses within the 90 to 105 day timeframe. (The contractor need not mail a notification if one or a few of the e-mails are returned as undeliverable, but one or more have been delivered successfully.) If the correspondence and special payment addresses are the same, the contractor shall send the second letter to the provider's practice location address; if the correspondence, practice, and special payments addresses are the same, the contractor shall send only one letter.*

*If no e-mail addresses exist in the enrollment record, the contractor shall mail the notice to the group's correspondence address.*

*The contractor shall include with the notification letter a spreadsheet identifying the individual providers to be revalidated. The spreadsheet shall contain the provider's name, NPI, and specialty; this information will be furnished as part of the list that CMS supplies.*

*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 need not receive a group notification letter; however, all reassignment information will be available at https://data.cms.gov/revalidation for providers to view.*

*The contractor shall designate an enrollment analyst for each of the large groups to coordinate revalidation activities. The group notification letter shall identify the designated enrollment analyst. The enrollment analyst shall work directly with the group's enrollment contact person or the authorized/delegated official on file.*

*Large groups may submit a spreadsheet identifying those providers that no longer practice at their group in lieu of submitting Form CMS-855R termination applications. A letter signed by*

*the authorized/delegated official of the group shall accompany the spreadsheet. This process, however, is only acceptable for large groups that are completing their revalidation and coordinating directly with the contractor.*

### *B. Mailing Revalidation Letters*

*Based on the due date identified on the list, the contractor shall send a revalidation notice (using the applicable letter in section 10.7 et seq. of this chapter) between 90 to 105 days prior to the revalidation due date. 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 contacts.*

*The contractor may send revalidation notices via e-mail if this option is consistent with the contractor's security requirements and capabilities. (The CMS list will include e-mail addresses derived from Section 2 and 13 of PECOS). When sending revalidation notices via e-mail, the contractor shall indicate "URGENT: Medicare Provider Enrollment Revalidation Request" in the subject line to differentiate this from other e-mails. The contractor shall include in the e-mail's body the applicable sample letter in section 10.7 et seq. of this chapter; the letter must not be an attachment to the e-mail or require that the provider receive a password to view the e-mail content. (Except as stated in the following paragraph, the contractor need not send a paper copy of the revalidation notice if sent via e-mail.) If the contractor sends the notice to multiple e-mail addresses but one notice is returned as undeliverable, the contractor need not mail a revalidation notice so long as one e-mail is delivered successfully.*

*If all of the e-mails 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 addresses are the same, the contractor shall send the second letter to the provider's practice location address. If the correspondence, practice, and special payments addresses are the same, the contractor need only send one letter.*

*If no e-mail addresses exist in the enrollment record or the contractor chooses the mail option, the contractor shall mail two revalidation notices to the provider's correspondence and special payment address and/or practice location address using the instructions outlined above.*

*When issuing revalidation notices to individual group members, the contractor shall include thereon identifying information of the organization (i.e., LBN, DBA name, TIN) to which the provider reassigns benefits in lieu of including the provider's PTANs. (Individual group members may be more familiar with the organization's LBN or DBA than with the latter's PTAN.) This should eliminate the need for the contractor to develop for PTANs not included on the revalidation application.*

*If one of the locations is incorrect or the letter is returned as undeliverable, the contractor shall re-send the returned letter to an address not used for the initial mailing. If all locations are the same and the contractor has exhausted all reasonable means of contacting the provider, the contractor shall deactivate the provider's enrollment via existing deactivation procedures.*

### *C. Interaction with Change Request*

*If the contractor receives a change of information (COI) application from the provider before it has mailed to the latter the revalidation letter, the contractor shall process the COI as normal and proceed with mailing the revalidation notice.*

*If the contractor receives a COI application from the provider after it 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.*

*If the contractor receives revalidation and COI applications concurrently, the contractor shall merge the two applications and process accordingly.*

*If the provider submits an application marked as a revalidation but that 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.*

### *D. Interaction with a Change of Ownership (CHOW)*

*The contractor shall not take revalidation action regarding a provider/supplier that is undergoing a CHOW that: (1) the contractor is currently processing; or (2) is pending review with the state agency. The contractor shall notify its PEOG BFL if a seller's enrollment record is due for revalidation and the contractor is currently processing the CHOW. The contractor shall include the seller and buyer enrollment record ID in its e-mail notification to its PEOG BFL.*

### *E. 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, the contractor shall process the reassignment and/or employment arrangement application. The supplier need not report the newly established reassignment/employment arrangement on the revalidation application, and the contractor shall not develop for the missing information; this is because the arrangement was established after the revalidation notice was issued. However, the contractor shall maintain the reassignment/employment arrangement information in the enrollment record when processing the revalidation application; this information shall not be overridden. If the supplier fails to respond to the revalidation request, all reassignments/employment arrangements shall be end-dated, including the newly established reassignment/employment arrangement. Consider the following illustration:*

*EXAMPLE: Dr. Doe submits a Form CMS-855R application 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 because the contractor is still processing the Form CMS-855R and has not yet approved the reassignment. 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.*

### *F. Revalidation Extension Requests*

*The contractor shall only accept extension requests from a provider that was not given the full 7 months' advance notice prior to their revalidation due date because the due date list was untimely posted to the CMS website. The contractor shall no longer accept extension requests from providers for any other reason.*

*If a delay occurs in posting the aforementioned list that prevents the provider or supplier from receiving the full advance notice, the contractor shall accept the provider/supplier's*

*extension request and grant an extension up to the full 6-month period from the date the list was posted (with no impact on their effective date). The provider/supplier may submit its request in writing (fax/e-mail permissible) or via phone, though the individual provider, authorized/delegated official, or contact person shall make the request.).*

## *10.4.5.2 – Non-Responses to Revalidation and Extension Requests*

***(Rev. 11020; Issued: 10-01-21; Effective: 10-29-21; Implementation: 10-29-21)***

### *A. Phone Calls*

*The contractor may (but is not required to) continue to contact providers via telephone or e-mail to communicate non-receipt of revalidation applications. The contractor shall continue to document all such communications with the provider.*

### *B. Pend Status*

*The contractor shall apply the payment hold (pend flag) in PECOS if the provider fails to respond to the revalidation request; the contractor shall perform this action within 25 days after the revalidation due date. The contractor may, but is not required to, notify the provider of the payment hold.*

*Since a payment hold of an individual group member can prevent payment to the entire group, the contractor shall issue a letter to the individual group members in lieu of the payment hold within 25 days after the revalidation due date. (The contractor shall use the applicable sample letter in section 10.7 et seq. (Revalidation Past Due Group Member Sample Letter).) The contractor may send the payment hold notice via e-mail if this option is consistent with the contractor's security requirements and capabilities. The CMS list (derived from Section 2 and 13 of the PECOS) will furnish the e-mail addresses. When sending payment hold notices via e-mail, the contractor shall indicate "URGENT: Revalidation Past Due" in the subject line to differentiate this from other e-mails. The letter should be included in the body of the e-mail; it shall not be an attachment to the e-mail or require that the contractor send a password to the provider to view the e-mail content.*

*The contractor need not send a paper copy of the payment hold notice if sent via e-mail. If the contractor sends the notice to multiple e-mail addresses but one is returned as undeliverable, the contractor need not mail a payment hold notice if one e-mail is delivered successfully.*

*If all e-mails are returned as undeliverable, paper payment hold notices shall be mailed to the provider's correspondence and special payment addresses. If the correspondence and special payment addresses are the same, the contractor shall send the second letter to the provider's practice location address. If the correspondence, practice, and special payments addresses are the same, the contractor shall only send one letter.*

*If no e-mail addresses exist in the enrollment record or the contractor chooses the mail option, the contractor shall mail the two payment hold notices to the provider's correspondence and special payment address and/or the practice location address using the instructions outlined above.*

*This requirement only applies to individual group members who reassign their benefits to a group and/or providers who have employment arrangements.*

### *C. Deactivation Actions*

*The contractor shall deactivate a provider's enrollment record for failure to respond to the revalidation request between days 60 – 75 after the revalidation due date; the contractor shall notify the provider using the applicable sample letter in section 10.7 et seq. (Model*

*Revalidation Deactivation Letter). The effective date shall be the date on which the contractor took the action.*

*If the contractor deactivates an individual for failure to respond to a revalidation request, it shall search his/her associate record to determine if he/she serves as a supervising physician on any independent diagnostic testing facility (IDTF) enrollment. If he/she does, the contractor shall disassociate him/her as the supervising physician for that entity. If he/she 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.*

## *10.4.5.3 – Receipt and Processing of Revalidation Applications*

***(Rev. 11020; Issued: 10-01-21; Effective: 10-29-21; Implementation: 10-29-21)***

### *A. General Situations*

*1. Unsolicited Applications*

*An unsolicited revalidation application is one: (1) received more than 7 months prior to the provider's established due date; or (2) involving a provider identified as TBD (to be determined) on the revalidation look-up tool. The contractor shall return such applications using the applicable sample return letter in section 10.7 et seq. within 20 business days of receipt. If applicable, the contractor shall also submit a request to CMS to have the application fee returned to the provider.*

*2. 7-Month Period and Signatures*

*The contractor shall accept and process a revalidation application submitted within 7 months of the provider's due date. The submission date of a revalidation application for providers 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 or delegated official.*

*3. Branches and Sub-Units*

*Any certified provider sub-unit or branch that has a separate provider agreement must revalidate on a separate Form CMS-855A. It cannot revalidate via the main provider's Form CMS-855A. If the sub-unit/branch has a separate CMS Certification Number (CCN) but not a separate provider agreement (e.g., hospital psychiatric unit, HHA branch), the sub-unit/branch can disclose the revalidation on the main provider's Form CMS-855A; this is because the sub-unit/branch is a practice location of the main provider and not a separately enrolled entity. Separate fees, too, are not required.*

*4. Collapse of PTANs*

*If the provider requests to collapse its PTANs per a revalidation, the contractor shall process said requests if appropriate (based on payment localities, etc.).*

*5. Voluntary Withdrawal*

*(This subsection (A)(5) does not apply to certified providers/suppliers. See section 10.6.1.3 of this chapter for instructions concerning certified provider/supplier voluntary terminations.)*

*If a non-certified supplier wishes to voluntarily withdraw from Medicare (including deactivating all active PTANs), the contractor shall accept this request via phone, U.S. mail, or fax from the individual supplier or the authorized/delegated official (on letterhead); the contractor shall not require the non-certified supplier to complete a Form CMS-855 or CMS-20134 application. If the contractor makes the request via telephone, the contractor shall document the telephone conversation (in accordance with section 10.6.19 et seq, of this chapter) and take the appropriate action in PECOS.*

***B. Development Required***

*1. General Instructions*

*If a revalidation application requires development (i.e., missing application fee, hardship request, reassignments and/or employment arrangements, documentation, signature, etc.), the contractor shall notify the provider via mail, phone, fax or e-mail. The contractor shall develop for all of the missing information in one development request. The provider has 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. (Note that the provider may submit a full Form CMS-855I or Sections 1, 2, 4, & 15 of the Form CMS-855I to report the missing reassignments and/or employment arrangements any time prior to their revalidation due date, even post-revalidation application approval.)*

*If the contractor can verify licensure and/or educational requirements (e.g., non-physician practitioner's degree or diploma) online, the contractor shall not require the provider to submit this documentation. If the supporting documentation currently exists in the provider's file, the provider need not submit that documentation again with their revalidation application; the contractor may utilize the existing documentation for verification. Residency information is not required as part of a revalidation. In addition, the contractor need not develop for data that is missing on the provider's revalidation application if the provider disclosed the information (1) elsewhere on the application or (2) in the supporting documentation submitted with the application, though with the exception of the following items:*

*(i) Adverse legal action data*
*(ii) LBN*
*(iii) Tax identification number (TIN)*
*(iv) NPI-legacy number combinations*
*(v) Supplier/Practitioner type*
*(vi) DBA name*
*(vii) Effective dates of sale/transfer/consolidation or indication of acceptance of assets/liabilities*

*The contractor shall not require providers to include the PTAN(s) in Section 2 or 4 of the revalidation application---provided that the provider included the information needed (NPI, TIN, LBN, DBA, etc.) for the contractor to appropriately make the association. If the PTAN was not submitted but is needed to make the connection, the contractor shall use the shared systems, PECOS, or its provider file(s) as a resource before developing with the provider.*

*The contractor shall not develop for the EFT form if the provider has the 05/10 or 09/13 version of the Form CMS-588 on file. If provider submits an EFT form with a bank letter or*

*voided check, the contractor 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 need not 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 the instructions in this chapter, the contractor shall document in the provider file that it found the missing information elsewhere in the enrollment package, with previously submitted applications, or with documentation currently uploaded in PECOS. (This excludes information that the contractor must verify at the current point in time (e.g., a license without a primary source verification method). Additionally, the contractor shall not utilize information submitted along with opt-out applications for enrollment application processing or vice-versa.*

*If 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 with 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.*

*If other missing information is not received within 30 days, the contractor shall deactivate the provider within 25 days after the development due date and notify the provider of the deactivation using the applicable sample letter in section 10.7 et seq. of this chapter. After deactivation, the provider must submit an entirely new application in order to reactivate their PTANs. The contractor may use any supporting documentation received (if needed) for subsequent application submissions.*

*The deactivation date shall be consistent with the latter of: (1) the revalidation due date; or (2) the date on which the deactivation occurred due to non-response or incomplete response to a development request for all provider business structures (e.g., organizations, sole proprietors, sole owners, etc.).*

*2. Illustrations*

*Consider the following examples that address the instructions in section 10.4.5.3(B)(1):*

*<u>SCENARIO #1</u> - 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 but only addresses the reassignment for Group A. The contractor develops with 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 remains in progress, the provider may submit a full Form CMS-855I or Sections 1, 2, 4, & 15 of the Form CMS-855I to report the missing reassignment information (even post-revalidation application approval). Here, the contractor processes the revalidation application to completion, and the provider experiences no break in billing.*

*<u>SCENARIO #2</u> - 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 with 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. In this situation, Group A's reassignment is revalidated, and the contractor shall deactivate Group B & C's reassignments and/or employment arrangements effective with the date on which the contractor took deactivation action due to non-response or incomplete response to a development request. The approval letter shall identify the reassignments and/or employment arrangements that were revalidated and those that were terminated with the effective date of the reassignment or termination. The provider must submit a full application (Form CMS-855R) to reactivate the reassignment. The reactivation effective date is based on the receipt date of the CMS-855R.*

*In Scenario #2, therefore: (i) the provider experiences a break in billing but the contractor only deactivates the non-response reassignments and/or employment arrangements; and (ii) the contractor revalidates the other reassignments and/or employment arrangements.)*

### *C. Revalidation Received after a Pend is Applied*

*If the contractor receives a revalidation application after applying a pend, it 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 e-mail a decision letter to the provider to notify the latter that the contractor has processed the revalidation application.*

### *D. Revalidation Received After a Deactivation Occurs*

*1. General Guidance*

*The contractor shall require a deactivated provider to submit a new, full application to reactivate their enrollment record. The contractor shall process the application as a reactivation. The provider shall maintain their original PTAN; however, the contractor shall reflect a gap in coverage (between the deactivation and the reactivation) on the existing PTAN using A/R codes in MCS and based on the application's receipt date. The provider will not receive reimbursement for dates of service in which they were non-compliant with Medicare requirements (deactivated for non-response to revalidation). The contractor shall reactivate group members (with the group enrollment) who had their reassignment associations terminated when the contractor deactivated the group. The effective dates assigned to the reassigned providers should align with the group's effective date per standard reactivation instructions.*

*2. Certified Providers and Certified Suppliers*

*Unless CMS instructs otherwise, the contractor shall allow a certified provider/supplier to maintain its original PTAN and effective date when the reactivation application is processed. (As stated in § 424.540(c), a deactivation does not terminate a certified provider/supplier agreement.) In addition, when processing the revalidation application after a deactivation occurs, the contractor shall not require the deactivated certified provider/supplier to obtain a new state surveyor accreditation as a condition of revalidation.*

### *E. Finalizing the Revalidation Application*

*Prior to processing the revalidation application to completion, the contractor shall:*

*(i) Ensure that a site visit (if applicable to the provider in question) occurs.*

*(ii) Ensure that the provider meets all applicable federal regulatory requirements regarding licensure, certification, and/or educational requirements.*

*(iii) Revalidate the provider's information based on the data in PECOS.*

*(iv) Verify the practice locations, although the contractor need not contact each location separately. The contractor shall: (1) verify the location(s) by contacting the contact person listed on the application; and (2) note the validation accordingly in the contractor's verification documentation per the instructions in this chapter.*

*(v) Ensure that the appropriate L&T record type andfinalization status are identified in PECOS.*

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

*(vii) Ensure that PECOS and the claims systems remain consistent. The contractor shall not directly update the shared systems without first updating PECOS when processing a revalidation (unless instructed otherwise in another CMS directive).*

*(viii) When processing is complete, issue an approval letter to the contact person (or the provider if no contact person is listed) via mail, fax, or e-mail. If the provider 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).*

### *F. Revalidation Reporting*

*The contractor need not submit reports on the 5th and 20th of each month for Cycle 2. However, the contractor shall maintain internally (i) the method of delivery for the provider revalidation notices and (ii) the date it sent the e-mail or letter. CMS may periodically request ad hoc reporting of this data. The data elements for ad-hoc reporting shall include, but are not limited to: (i) the revalidation notification's delivery date, delivery method, and delivery address; (ii) deactivation date; (iii) provider response date; (iv) reactivation date; and (v) application finalization date, etc.*

## *10.4.6 – Reactivations*

***(Rev. 11020; Issued: 10-01-21; Effective: 10-29-21; Implementation: 10-29-21)***

### *A. Form CMS-855 or CMS-20134 Reactivations – Screening Levels*

#### *1. Limited*

*The contractor shall process reactivation applications from providers in the "limited" level of categorical screening in accordance with existing instructions.*

#### *2. Moderate*

*The contractor shall process reactivation applications from providers in the "moderate" level of categorical screening (including existing HHAs and DMEPOS suppliers) in*

*accordance with the screening procedures for this category. A site visit is thus needed prior to the contractor's final decision regarding the application.*

### *3. High*

*The contractor shall process reactivation applications from providers in the "high" level of categorical screening in accordance with the screening procedures for this category. A site visit is thus needed prior to the contractor's final decision regarding the application.*

## *B. Form CMS-855B and CMS-855I Non-Certified Supplier Reactivations*

*If the contractor approves a Part B non-certified supplier's reactivation application, the reactivation effective date shall be the date the contractor received the application that was processed to completion. In addition, upon reactivating a Part B non-certified supplier, the contractor shall issue a new PTAN.*

*Unless CMS instructs otherwise, the contractor shall grant retrospective billing privileges to reactivating providers consistent with the instructions in this chapter. This includes providers deactivated for not responding to a revalidation request.*

## *C. Form CMS-855A or CMS-855B Certified Provider or Supplier Reactivations*

*With the exception of HHAs, reactivation of a certified provider/supplier does not require a new state survey, 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 it can be reactivated.*

## *D. Reactivations - Deactivation for Reasons Other Than Non-Submission of a Claim*

*To reactivate its billing privileges, a provider deactivated for failing to timely notify the contractor of a change of information must submit a complete Medicare enrollment application.*

## *E. Miscellaneous Policies*

### *1. Previous Withdrawn Status*

*A provider 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 must complete an initial enrollment application and, if applicable, pay an application fee.*

### *2. Deactivation for Non-Billing*

*For providers deactivated for non-billing, the provider must submit a complete Form CMS-855 or CMS-20134 enrollment application via paper or PECOS Web.*

### *3. Contractor Timeliness Standards*

*For Form CMS-855 or CMS-20134 reactivation applications, the timeliness requirements in section 10.5 et seq. of this chapter pertaining to initial enrollment applications apply. Except as otherwise stated in this chapter or another CMS directive, the contractor shall validate all of the information on the application as it would with an initial application.*

## *10.4.7 – Revocations*
***(Rev. 11020; Issued: 10-01-21; Effective: 10-29-21; Implementation: 10-29-21)***

*In executing the instructions in section 10.4.7 et seq. of this chapter, the contractor shall also adhere to:*

*(i) All supplemental and any superseding instructions in section 10.6.6 of this chapter concerning final adverse actions (e.g., referrals to PEOG);*

*(ii) The letter formats and verbiage in section 10.7 et seq. of this chapter; and*

*(iii) Any other directive that, per CMS, explicitly pre-empts any instruction(s) in section 10.4.7 et seq. of this chapter.*

*If any instruction in categories (i) through (iii) above conflict with that in section 10.4.7 et seq., the instruction in (i), (ii), or (iii) applies. In addition, the contractor shall adhere to any instruction in (i), (ii), or (iii) above that addresses a revocation-related matter not discussed in section 10.4.7 et seq.*

## *10.4.7.1 – Revocations – Background and General Requirements*
***(Rev. 11020; Issued: 10-01-21; Effective: 10-29-21; Implementation: 10-29-21)***

### *A. Introduction*

*Medicare revokes currently enrolled providers/suppliers' Medicare billing privileges and corresponding provider/supplier agreements pursuant to federal regulations at 42 CFR § 424.535. (A Medicare revocation is a "termination" as defined at 42 CFR § 455.101.) A revocation of Medicare billing privileges does not affect a provider's ability to submit claims to non-Medicare payers using their NPI.*

*If the contractor determines that a provider's billing privileges should be revoked or receives information from PEOG that a provider'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 10.4.7.1 includes, but is not limited to, information concerning the contractor's responsibilities to:*

*(i) Prepare a draft revocation letter;*

*(ii) E-mail the letter to the appropriate PEOG mailbox with additional pertinent information regarding the basis for revocation;*

*(iii) Receive PEOG's determination and follow PEOG's instructions regarding the case;*

*(iv) If PEOG authorizes the revocation: (a) revoke the provider's billing privileges effective on the appropriate date; (b) establish the applicable reenrollment bar; (c) update PECOS with the appropriate reenrollment bar length; (d) assess an overpayment, as applicable; and (e) send the revocation letter (including affording appeal rights) to the provider via certified mail.*

### *B. Administrative Requirements*

*This section 10.4.7.1(B) addresses (in greater specificity than section 10.4.7.1(A)) certain contractor administrative activities pertaining to revocations. As stated in section*

*10.4.7.1(A), however, the contractor shall take into account the instructions in sections 10.6.6 and 10.7 et seq.*

***1. Processing Timeframes***

*If the contractor receives approval from PEOG (or receives an unrelated request from PEOG) to revoke a provider's billing privileges, the contractor shall complete all steps associated with the revocation no later than five (5) business days from the date it received PEOG's approval/request. The contractor shall notify PEOG that it has completed all revocation steps no later than three (3) business days after completion.*

***2. Revocation Letters - Contents***

***i. General Information***

*When the contractor discovers a basis for revoking a provider's enrollment under 42 CFR § 424.535 - and, if applicable under section 10.6.6 of this chapter or another CMS directive, receives PEOG's approval for the revocation - the contractor shall revoke billing privileges and notify the provider by letter. The revocation letter shall contain:*

*(a) A legal (i.e., regulatory, such as § 424.535(a)(3) or §424.535(a)(9)) basis for each reason for revocation (the contractor shall not use provisions from this chapter as the basis for revocation);*

*(b) A clear explanation of why Medicare billing privileges are being revoked, including the facts or evidence that the contractor used in making its determination;*

*(c) An explanation of why the provider does not meet the applicable enrollment criteria;*

*(d) The effective date of the revocation;*

*(e) Procedures for submitting a CAP (if revoked under § 424.535(a)(1));*

*(f) Complete and accurate information about the provider's appeal rights;*

*(g) Any other information contained in or required by the applicable model letter in section 10.7 et seq.*

***ii. One Letter Per Enrollment***

*The contractor shall issue a unique revocation letter per enrollment. For example, regarding revocation letters for solely owned organizations, when revoking a physician/non-physician practitioner's billing privileges and those of his/her solely owned organization, the contractor shall issue **two** revocation letter: one for the individual and the other for the solely owned organization. The contractor shall not issue one letter to convey revoked Medicare billing privileges for both the individual and the solely owned organization.*

***3. Revocation Letters – PEOG Approval***

*Using the guidance in this section 10.4.7.1(B) et seq., section 10.6.6, and section 10.7 et seq., the contractor shall determine whether it must submit its draft revocation letter to PEOG for approval prior to sending it to the provider.*

***i. Prior PEOG Approval Required***

*If prior PEOG approval of the letter is required, the contractor shall submit the letter to the appropriate PEOG mailbox for PEOG review. PEOG will examine the letter for technical correctness and determine matters such as: (1) whether the revocation affects the revoked provider's other locations; (2) the length and application of the reenrollment bar; and (3) the revocation effective date. PEOG will notify the contractor of the outcome of its review and instruct the contractor how to proceed.*

*The contractor shall not begin finalizing the revocation until it receives guidance from PEOG.*

*The contractor may not alter an approved revocation letter; if it needs to revise said letter, the contractor shall submit the letter to PEOG for a new review via the process described above.*

*Unless CMS has directed otherwise, the contractor shall document and report the impacted application/enrollment in its Monthly Status Reports.*

***ii. 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) (except as otherwise required in this chapter or another CMS directive)*
- *§ 424.535(a)(6)*
- *§ 424.535(a)(11)*

***4. Issuing the Revocation Letter to the Provider***

*The contractor shall send revocation letters by USPS certified mail. (The contractor may e-mail a follow-up copy of the letter after issuing it via USPS certified mail.) The contractor shall date and mail the letter on the same business day.*

## *10.4.7.2 – Revocation Effective Dates*

***(Rev. 11020; Issued: 10-01-21; Effective: 10-29-21; Implementation: 10-29-21)***

***A. General Principle***

*The contractor shall apply a revocation effective date based upon federal regulations at § 424.535(g). In general, and as discussed below, these dates are either prospective or retroactive.*

***B. Revocations with Retroactive Effective Dates***

*The following revocation reasons require a retroactive effective date under § 424.535(g):*

*(1) Federal exclusion or debarment;*
*(2) Felony conviction as described in 42 CFR §§ 424.535(a)(3) and 1001.2;*
*(3) License suspension or revocation; or*
*(4) Determination that the provider or supplier is no longer operational*

*A revocation based upon any of these reasons 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 is no longer operational. To illustrate, for a*

*revocation involving a licensure revocation/suspension, the revocation effective date (and the date listed on the revocation letter) shall be the date of the actual license revocation/suspension.*

***C. 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) for revocations not based upon one of the four reasons listed in §§ 424.535(g) and section 10.4.7.2(B) above (e.g., § 424.535(a)(8) -- abuse of billing).*

***D. Revocations Based Upon More than One Reason***

*When a revocation involves more than one reason, the contractor shall determine whether any of the grounds require a retroactive effective dates (listed in §§ 424.535(g) and section 10.4.7.2(B) above; if a retroactive date is indeed implicated, the contractor shall apply the appropriate retroactive date.*

## *10.4.7.3 – Revocation Reasons*

***(Rev. 11020; Issued: 10-01-21; Effective: 10-29-21; Implementation: 10-29-21)***

*Sections 10.4.7.3(A) through (T) list the revocation reasons in 42 CFR § 424.535. Section 10.4.7.3(U) discusses extensions of revocations per 42 CFR § 424.535(i).*

***A. 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: (1) the provider/supplier no longer has a physical business address or mobile unit where services can be rendered; (2) the provider/supplier does not have a place where patient records are stored to determine the amounts due such provider or other person; and/or (3) the provider/supplier no longer meets or maintains general enrollment requirements. Noncompliance also includes situations when the provider/supplier has failed to pay any user fees as assessed under 42 CFR Part 488.*

*Other situations (some of which were mentioned in the previous paragraph) 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/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 apply if CMS has 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.*

*(Concerning 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/supplier type.)*

*Special Instructions Regarding Certified Providers/Suppliers – The SOG Location may involuntarily terminate a certified provider/supplier if the latter no longer meets CMS requirements, conditions of participation, or conditions of coverage. When this occurs, CMS terminates the provider'/supplier's provider agreement and notifies the contractor thereof. Upon receipt of the CMS notice (and except as otherwise stated in this chapter), the contractor shall follow the revocation procedures in this chapter (including, as applicable, those in section 10.6.6)), using § 424.535(a)(1) as the revocation basis; the contractor shall not process the involuntary termination as a deactivation based upon a voluntary withdrawal from Medicare.*

*Note that the contractor need not (but certainly may) contact the SOG Location to obtain further details of the termination.*

***B. 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 non-procurement program or activity in accordance with the FASA implementing regulations and the Department of Health and Human Services non-procurement common rule at 45 CFR part 76."*

*If the contractor finds an excluded party (and unless section 10.6.6 states otherwise, in which case the latter section takes precedence), the contractor shall notify its 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 OIG for further investigation.*

***C. 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. [Under § 424.535(a)(3)(ii),] [o]ffenses 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 that would result in mandatory exclusion under section 1128(a) of the Act.*

*[Under § 424.535(a)(3)(iii),] 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 reenrollment bar issued pursuant to 42 CFR § 424.535(c) does not preclude CMS or its contractors from denying reenrollment to a provider that (i) was convicted of a felony within the preceding 10-year period or (ii) otherwise does not meet all criteria necessary to enroll in Medicare.*

***D. 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.)"*

***E. 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."*

***F. Revocation Reason 6 - Hardship Exception Denial and Fee Not Paid (42 CFR §424.535(a)(6))***

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

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

*(iii) Either of the following occurs:*

- *CMS is not able to deposit the full application amount into a government-owned account; or*

- *The funds are not able to be credited to the United States Treasury;*

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

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

***G. 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."*

***H. 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**: Concerning (a)(8), PEOG -- rather than the contractor -- will (1) make all determinations regarding whether a provider 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.)*

***I. 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 § 424.535(a)(9) (and except as otherwise stated in section 10.6.6):*

- *If the provider 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 provider's address has changed but the provider has not notified the contractor thereof 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 action 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 DMEPOS supplier reports a change of information 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).*

***J. 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."*

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

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

***L. 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." Under § 424.535(a)(12)(ii), "Medicare may not revoke [a provider/supplier's Medicare billing*

*privileges] unless and until the provider or supplier has exhausted all applicable appeal rights."*

*In making its determination, 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."*

***M. 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's or other eligible professional's ability to prescribe drugs."*

***N. Revocation Reason 14 – Improper Prescribing Practices (42 CFR § 424.535(a)(14))***

***"CMS determines that the physician or other eligible professional has a pattern or practice of prescribing Part B or 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. In making this determination, CMS considers the following factors:***

*(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.*

***(ii) The pattern or practice of prescribing fails to meet Medicare requirements. In making this determination, CMS considers the following factors:***

*(A) Whether the physician or eligible professional has a pattern or practice of prescribing without valid prescribing authority.*

*(B) Whether the physician or eligible professional has a pattern or practice of prescribing for controlled substances outside the scope of the prescriber's DEA registration.*

*(C) Whether the physician or eligible professional has a pattern or practice of prescribing drugs for indications that were not medically accepted - that is, for indications neither approved by the FDA nor medically accepted under section 1860D-2(e)(4) of the Act - and whether there is evidence that the physician or eligible professional acted in reckless disregard for the health and safety of the patient."*

*(**NOTE**: Concerning (a)(14), PEOG -- rather than the contractor -- will (1) make all determinations regarding whether a provider/supplier has a pattern or practice of prescribing Part B or D drugs; (2) consider the relevant factors; and (3) accumulate all information needed to make such determinations.)*

***O. 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." In determining whether a revocation is appropriate, CMS considers the following factors:*

*"(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/supplier has an existing debt that has been referred to the Department of Treasury.)*

***P. 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 reenrollment bar period has not expired." In making its determination, CMS considers the following factors:*

*"(i) Owning and managing employees and organizations (regardless of whether they have been disclosed on the Form CMS-855 [or CMS-20134] application);*

*(ii) Geographic location;*

*(iii) Provider or supplier type;*

*(iv) Business structure; or*

*(v) Any evidence indicating 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 reenrollment bar."*

***(NOTE**: Concerning (a)(18), PEOG – rather than the contractor – will make all determinations regarding whether a provider/supplier was revoked under a different name, numerical identifier, or business identity.)*

***Q. Revocation Reason 19 – Affiliation that Poses an Undue Risk (42 CFR § 424.535(a)(19))***

***1. Specific Reason***

*"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." In making this determination, CMS considers the following factors listed in 42 CFR § 424.519(f)(1) through (6):*

*"(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/supplier's disclosable event [under § 424.519(b)]:*

*(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; and (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.*

*(6) Any other evidence that CMS deems relevant to its determination."*

***2. Definition of Affiliation***

*For purposes of § 424.519 only, 42 CFR § 424.502 defines "affiliation" 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**: Concerning (a)(19), PEOG -- rather than the contractor -- will make all determinations regarding whether a provider/supplier has an affiliation per § 424.519 that poses an undue risk of fraud, waste, and abuse.)*

***R. Revocation Reason 20 – Billing from a Non-Compliant Location (42 CFR § 424.535(a)(20))***

*"CMS may revoke a provider's or supplier's Medicare enrollment or enrollments, even if all of the practice locations associated with a particular enrollment comply with Medicare enrollment requirements, if 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. In determining whether and how many of the provider/supplier's enrollments (involving the non-compliant location or other locations) should be revoked, CMS considers the following factors [enumerated in § 424.535(a)(20)(i) through (vii)]:*

- *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;*
- *The length of time that the location was considered non-compliant;*
- *The 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: Concerning (a)(20), PEOG – rather than the contractor – will make all determinations regarding whether a provider/supplier has performed services or furnished items from a location that did not comply with Medicare enrollment requirements.)*

***S. 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 [enumerated in § 424.535(i) through (ix)]:*

- *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: Concerning (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).*

***T. Revocation Reason 22 – Patient Harm (42 CFR § 424.535(a)(22))***

*The physician or other 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 [enumerated in § 424.535(a)(22)(i)(A) through (E)):*

*(A) The nature of the patient harm.*

*(B) The nature of the physician's or other eligible professional's conduct.*

*(C) 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:*

*(i) License restriction(s) pertaining to certain procedures or practices.*
*(ii) Required compliance appearances before State medical board members.*
*(iii) 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).*

*(iv) Administrative or monetary penalties.*
*(v) Formal reprimand(s).*

*(D) If applicable, the nature of the IRO determination(s).*

*(E) The number of patients impacted by the physician/other eligible professional's conduct and the degree of harm thereto or impact upon."*

*(Per 42 CFR § 424.535(a)(22)(ii), paragraph (a)(22) 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.)*

### *U. Extension of Revocation*

*If a provider's Medicare enrollment is revoked under § 424.535(a), CMS may revoke any and all of the provider'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 other enrollments, CMS considers the following factors:*

*(i) The reason for the revocation and the facts of the case,*

*(ii) Whether any final adverse actions have been imposed against the provider or supplier regarding its other enrollments,*

*(iii) The number and type(s) of other enrollments, and*

*(iv) Any other information that CMS deems relevant to its determination.*

## *10.4.7.4 – Reenrollment Bar*
***(Rev. 11020; Issued: 10-01-21; Effective: 10-29-21; Implementation: 10-29-21)***

*If any inconsistency exists between an instruction in this section 10.4.7.4 and a directive in section 10.6.6, the latter instruction takes precedence. In addition, the contractor shall adhere to any instruction in section 10.6.6 that addresses a reenrollment bar matter not discussed in section 10.4.7.4.*

### *A. Background*

*As stated in 42 CFR § 424.535(c), if a provider/supplier 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 reenrollment bar. The reenrollment 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 reenrollment bar of up to 20 years if the provider/supplier is being revoked from Medicare for the second time.*

*Per § 424.535(c), the reenrollment bar does not apply if the revocation: (i) is based on § 424.535(a)(1); and (ii) stems from a provider/supplier's failure to respond timely to a revalidation request or other request for information. If both of these conditions are met, no reenrollment bar will be applied.*

*The contractor shall update PECOS to reflect that the individual cannot participate in Medicare for the applicable length of the reenrollment bar. Except as otherwise stated in this chapter, PEOG (rather than the contractor) determines reenrollment bars that exceed 3 years.*

*In addition, CMS may add up to 3 more years to the provider/supplier's reenrollment bar if it determines that the provider/supplier is attempting to circumvent its existing reenrollment bar.*

### *B. 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. 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*

*The following revocation reasons will receive reenrollment bar lengths per CMS discretion:*

- *§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)*
- *§424.535(a)(22) (Patient Harm) will receive reenrollment bar lengths per CMS' discretion.*

### *C. Applicability of Bar*

*In general, and unless stated otherwise above, any reenrollment bar at a minimum applies to: (1) all practice locations under the provider's PECOS or legacy enrollment record; and (2) any effort to reestablish 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 whether a revoked provider is attempting to reestablish 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:*

*SCENARIO 1 - 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.*

*SCENARIO 2 - 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.*

*SCENARIO 3 - 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. John Smith is listed as a 75 percent owner.*

### *D. Discussing Provider Enrollment Appeals Process in Revocation Letter*

*(If a conflict exists between the instructions in this section 10.4.7.4(D) and those in either (i) those in section 10.6.18 or (ii) the language in the applicable model letter in section 10.7 et seq., the guidance in section 10.6.18 or the model letter takes precedence.)*

*In the revocation letter, the contractor shall include information concerning the provider's appeal rights. The following table summarizes where the provider must send a corrective action plan (CAP) and/or reconsideration request.*

| | ***CAP requests should be sent to:*** | | ***Reconsideration request should be sent to:*** | |
|---|---|---|---|---|
| ***Revocation Regulation*** | ***titutional**** | ***Non-institutional*** | ***tutional**** | ***institutional*** |
| *424.535(a)(1) related to an enrollment requirement (i.e., 425.516)* | *Alone or in combination: CMS* | *IC* | *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* | *CAP rights* | *CAP rights* | *CMS* | *CMS* |
| *424.535(a)(2) Debarment* | *CAP rights* | *CAP rights* | *CMS* | *CMS* |
| *424.535(a)(3)* | *CAP rights* | *CAP rights* | *CMS* | *CMS* |
| *424.535(a)(4)* | *CAP rights* | *CAP rights* | *CMS* | *CMS* |
| *424.535(a)(5)* | *CAP rights* | *CAP rights* | *CMS* | *MAC* |
| *424.535(a)(6)* | *CAP rights* | *CAP rights* | *CMS* | *MAC* |
| *424.535(a)(7)* | *CAP rights* | *CAP rights* | *CMS* | *CMS* |
| *424.535(a)(8)* | *CAP rights* | *CAP rights* | *CMS* | *CMS* |
| *424.535(a)(8)* | *CAP rights* | *CAP rights* | *CMS* | *CMS* |
| *424.535(a)(9)* | *CAP rights* | *CAP rights* | *CMS* | *MAC* |
| *424.535(a)(10)* | *CAP rights* | *CAP rights* | *CMS* | *CMS* |
| *424.535(a)(11)* | *CAP rights* | *CAP rights* | *CMS* | *CMS* |
| *424.535(a)(12)* | *CAP rights* | *CAP rights* | *CMS* | *CMS* |
| *424.535(a)(13)* | *CAP rights* | *CAP rights* | *CMS* | *CMS* |
| *424.535(a)(14)* | *CAP rights* | *CAP rights* | *CMS* | *CMS* |
| *424.535(a)(17)* | *CAP rights* | *CAP rights* | *CMS* | *CMS* |
| *424.535(a)(18)* | *CAP rights* | *CAP rights* | *CMS* | *CMS* |
| *424.535(a)(19)* | *CAP rights* | *CAP rights* | *CMS* | *CMS* |
| *424.535(a)(20)* | *CAP rights* | *CAP rights* | *CMS* | *CMS* |
| *424.535(a)(21)* | *CAP rights* | *CAP rights* | *CMS* | *CMS* |
| *424.535(a)(22)* | *CAP rights* | *CAP rights* | *CMS* | *CMS* |

* *Institutional providers:*

- *Ambulance Service Supplier*

- *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)*
- *Intensive Cardiac Rehabilitation*
- *Indian Health Service Facility*
- *Mammography Screening Centers*
- *Mass Immunization/Flu Roster Billers*
- *Medicare Diabetes Prevention Program (MDPP) Suppliers*
- *Opioid Treatment Centers (OTPs)*
- *Organ Procurement Organizations (OPOs)*
- *Outpatient Physical Therapy/Outpatient Speech Pathology Services (OPT/OSP)*
- *Pharmacies*
- *Portable X-Ray Suppliers (PXRSs)*
- *Radiation Therapy Centers*
- *Rehabilitation Services*
- *Religious Non-Medical Health Care Institutions (RNCHIs)*
- *Rural Health Clinics (RHCs)*
- *Skilled Nursing Facilities (SNFs)*

*CMS defines "institutional provider" in 42 CFR § 424.502 to mean any provider/supplier that submits a paper Medicare enrollment application using the Form CMS-855A, Form CMS-855B (except physician and non-physician practitioner organizations), or Form CMS-855S, or the associated Internet-based PECOS enrollment application.*

## *10.4.7.5 – Additional Revocation Policies*

***(Rev. 11020; Issued: 10-01-21; Effective: 10-29-21; Implementation: 10-29-21)***

### *A. 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 § 424.535(h) impacts the requirements of 42 CFR § 424.44 regarding the timely filing of claims.*

### *B. Reporting Revocations/Terminations to the State Medicaid Agencies and Children's Health Program (CHIP)*

*(If the instructions in this section 10.4.7.5(B) conflict with those in another CMS directive, the latter takes precedence.)*

*Section 6401(b)(2) of the Patient Protection and Affordable Health Care Act (i.e., the Affordable Care Act) was enacted on March 23, 2010. It requires that CMS establish a process for making available to each State Medicaid Plan or Child Health Plan the name, NPI, and other identifying information regarding any revoked or denied Medicare provider/supplier. Accordingly, CMS provides 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 via the Share Point Ensemble site*

- *Review the monthly revoked and denied provider list for the names of Medicare providers revoked and denied in PECOS*

- *Document any appeal actions a provider/supplier may have submitted after the provider/supplier's revocation or denial*

- *Update the last three columns on the tab named "Filtered Revocations" of the spreadsheet for every provider/supplier revocation or denial*

*The contractor shall not make any other modifications to the format of this form or its contents.*

*The following 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/suppliers, the contractor shall access the PEOG appeals log via the Share Point Ensemble site to determine the appeal status to include on the spreadsheet.*

*The contractor shall submit their completed reports by the 20th of each month to the CGI Share Point Ensemble site.*

### *C. Opting-Out after Revocation*

*Revoked suppliers cannot 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 Medicare-revoked, he cannot opt-out and order back and knee orthoses for his patients.*

### *D. Overpayments Based Upon Revocations*

*The contractor shall commence 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 Part 405, subpart C.*

*If a revocation has a prospective effective date, the contractor shall assess an overpayment back to the 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 as reflected in PECOS and in MCS or FISS. Again, in determining an overpayment, the contractor shall use the starting date upon which claims are ineligible for reimbursement, 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).*

### *E. Other Sources of Potential Bases for Revocations*

*When CMS instructs the contractor to take revocation action, PEOG communicates such direction; neither the UPIC, the state agency, CMS Field Office, nor CMS Regional Office (RO) (including SOG Location) personnel can direct a contractor to revoke a provider/supplier. However, some of these entities may refer a potential revocation to PEOG. This section 10.4.7.5(E) discusses the operational aspects of these referrals.*

#### *1. UPICs*

*a. Background*

*If, through its investigations, the UPIC believes that a particular provider/supplier's Medicare billing privileges should be revoked, it shall develop a case file - including the*

*reason(s) for revocation and the data described in subsection (E)(1)(b) below - and submit the file and all supporting documentation to PEOG.*

*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) instruct the applicable contractor to revoke the provider/supplier; and (2) notify the applicable contracting officer's representative (COR).*

*If the contractor receives a direct request from a UPIC to revoke a provider/supplier, it shall refer the matter to its PEOG BFL if it is unsure whether the UPIC received prior PEOG approval of the revocation.*

*b. Contents of Request*

*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 (PTAN); National Provider Identifier (NPI); 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)*

***2. CMS Field Office or RO Revocations***

*If a CMS Field Office (FO) or (RO) believes that Revocation Reason 8 (see 42 CFR § 424.535(a)(8) is appropriate in a certain case), 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 NPI and associated PTAN(s)), and locations of the provider/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; and (2) accordingly notify the FO/RO.*

*(See section 10.4.3 of this chapter for information on the contractor's responsibilities concerning involuntary terminations received from the SOG Location.)*

***3. OIG Identified Revocations***

*PEOG is responsible for actions based on HHS OIG Identified revocations.*

***F. MDPP Supplier Revocation for Use of an Ineligible Coach***

***1. Background***

*Section 424.205(h)(1)(v) established a new revocation reason for MDPP suppliers. It permits revocation if 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 revocation reason(s) - and submit the file and all supporting documentation to PEOG. The contractor shall provide PEOG with the information described in section 10.4.7.5(E)(1)(b).*

*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) instruct the contractor to revoke the provider/supplier; and (2) notify the applicable COR.*

*If the contractor receives a direct request from a UPIC to revoke a provider/supplier, it shall refer the matter to its PEOG BFL if it is unsure whether the UPIC received prior PEOG approval of the revocation.*

***2. Effective Dates***

*An MDPP supplier revoked under § 424.205(h)(1)(v) does not have CAP rights. The revocation becomes effective 30 days after the contractor sends notice of the revocation.*

***3. Reenrollment Bar***

*As stated in § 424.205(h), if an MDPP supplier has its billing privileges revoked, it is barred from participating in Medicare from the effective date of the revocation until the end of the reenrollment bar. The reenrollment 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.*

## *10.4.8 – Deactivations*
***(Rev. 11020; Issued: 10-01-21; Effective: 10-29-21; Implementation: 10-29-21)***

### *A. Bases for Contractor Action*

*Unless indicated otherwise in this chapter or in another CMS instruction or directive, the contractor shall – without prior approval from its PEOG BFL - deactivate a provider/supplier's entire enrollment record and Medicare billing privileges when:*

- *A provider/supplier fails to respond to a revalidation request;*
- *A provider/supplier fails to respond timely to a revalidation development request;*
- *A provider/supplier is enrolled in an approved status without an active reassignment or practice location for 90 days or longer; or*
- *A provider/supplier deactivates an EFT agreement and remains enrolled but does not submit a new EFT agreement within 90 days.*

*The contractor shall not take deactivation action except as specified in this chapter or other CMS directives.*

### *B. Regulatory Reasons for Deactivation in § 424.540(a)*

*Section 424.540(a) lists three deactivation grounds:*

*Section 424.540(a)(1) - The provider/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 claim submission through the last day of the 12th month without a submitted claim.*

*Section 424.540(a)(2) - The provider/supplier fails to report a change in ownership or control (as specified in § 424.550(b)) within (a) 30 calendar days of when the change occurred, or (b) 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. If the provider/supplier submits a change of information indicating a change that was not reported within 90 days of the change occurring and (a) the contractor did not previously take administrative action against the provider/supplier and (b) no revocation action is applicable, the contractor should process the change of information without deactivating the provider/supplier's enrollment.*

*Section 424.540(a)(3) - A provider/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.*

### *C. Effective Dates*

*The effective dates of a deactivation are as follows:*

*a. Non-Billing (§ 424.540(a)(1)) – Unless stated otherwise in this chapter or another CMS directive, the effective date is the date the action is taken.*

*b. Failure to Report or Furnish Information (§ 424.540(a)(2) and (3)) – Unless stated otherwise in this chapter or another CMS directive. The effective date is the date the action is taken.*

*c. The "36-Month Rule" for HHAs – CMS' provider enrollment staff will determine the effective date during its review of the case.*

***D. Miscellaneous***

*a. The deactivation of Medicare billing privileges does not affect a provider/supplier's participation agreement.*

*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 PEOG BFL for review and approval. The only exception for PEOG BFL review and approval is deactivations due to failure to comply with a revalidation request.*

## *10.4.8.1 – Deactivation Rebuttals*

***(Rev. 11020; Issued: 10-01-21; Effective: 10-29-21; Implementation: 10-29-21)***

***A. Background***

*Pursuant to 42 CFR § 424.545(b), a provider/supplier whose Medicare billing privileges have been deactivated under 42 CFR § 424.540(a) may file a rebuttal in accordance with 42 CFR § 405.374. A rebuttal is an opportunity for the provider/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/supplier while a rebuttal submission is pending or during the rebuttal submission timeframe, the contractor shall process the application consistent with current processing instructions. 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: (1) the submitted application is required to reactivate the provider/supplier's enrollment; or (2) if there are new changes being reported. If an application (1) is received while a rebuttal submission is pending, (2) is approved prior to the issuance of a rebuttal determination, and (3) results in the provider's/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.*

***B. Notification Letters for Deactivations***

*If a basis is found to deactivate a provider/supplier's Medicare billing privileges under one of the regulatory authorities in 42 CFR § 424.540, the contractor shall deactivate the provider/supplier unless another CMS direction applies. If a revocation authority is applicable, the contractor shall follow the instructions in section 10.4.7 et seq. of this chapter in lieu of deactivating the enrollment. If no revocation authority applies, 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/ supplier's Medicare billing privileges are being deactivated. The contractor shall send the deactivation notification letter via hard-copy mail and via e-mail (if a valid email address is available); the contractor should also send the notice via fax if a valid fax number is available. All notifications shall be saved in PDF format, and all notification letters shall be mailed on the same date listed on the letter.*

### *C. 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, e-mail, and/or fax;*

*b. Must specify the facts or issues with which the provider/supplier disagrees, and the reasons for disagreement;*

*c. Should include all documentation and information the provider/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 CFR § 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/ supplier. This statement is sufficient to constitute notice. If the legal representative is not an attorney, the provider/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/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 development 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 (1) is not appropriately signed and no response is received to the development request (if applicable), (2) is untimely (as described above), (3) does not specify the facts or issues with which the provider/supplier disagrees and the reasons for disagreement, or (4) 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/supplier's control that prevented the timely submission of a rebuttal. These uncontrollable circumstances do not include the provider/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 5 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. Accordingly, 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, the rebuttal shall be accepted as timely if received by the next business day.*

*Consider the following illustration:*

*EXAMPLE: A deactivation notice is dated April 8, 2018. The provider/supplier is presumed to have received the deactivation notice on April 13, 2018. The provider/ 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/supplier's responsibility to timely update its enrollment record to reflect any changes to the provider/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/ 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/supplier met the enrollment requirements and if billing privileges were deactivated appropriately. All materials received by the provider/supplier shall be considered by the contractor in its review.*

***4. Reason-Specific Instructions***

*a. § 424.540(a)(1)*

*For deactivations under § 424.540(a)(1), the contractor shall review submitted documentation and internal systems to confirm whether billing occurred during the 12-month period preceding the date of deactivation, starting with the 1st day of the 1st month 12 months prior to the date of deactivation. If it is confirmed that billing occurred within 12 months, the contractor shall issue a favorable rebuttal determination. If no billing occurred during the 12-month period prior to the date of deactivation, the contractor shall issue an unfavorable rebuttal determination. Consider the following illustration:*

*EXAMPLE: Dr. Awesome has been enrolled in Medicare 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. An unfavorable determination would therefore be appropriate in this scenario, for the deactivation was justified.*

*b. § 424.540(a)(2)*

*For deactivations under 42 CFR § 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/supplier's Medicare billing privileges to an approved status. If it was not submitted properly and timely, the contractor shall deny the rebuttal request, for 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/supplier of the deactivation was sent to the correct address as instructed in section 10.7 et seq. 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 illustration:*

*<u>EXAMPLE</u>: 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. Thus, an unfavorable rebuttal determination would be appropriate in this scenario, as the deactivation was justified.*

*c. § 424.540(a)(3)*

*For deactivations under 42 CFR § 424.540(a)(3), the contractor shall review all submitted documentation and internal records to determine whether the provider/ 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 scenario:*

*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. Accordingly, an unfavorable rebuttal determination would be appropriate in this scenario, as the deactivation was justified.*

### *D. Determination*

*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 e-mail (if a valid e-mail 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, and 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/supplier, it shall make the necessary modification(s) to the provider/supplier's Medicare billing privileges within 10 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/supplier, the provider/ 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/ 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 its rebuttal determination letter. The contractor shall not reinstate the provider/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/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.*

***E. No Further Review***

*Pursuant to 42 CFR § 405.375(c), a determination made regarding a rebuttal request is not an initial determination and is not subject to further review. Thus, no additional appeal rights shall be included on any rebuttal determination letter.*