CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-08 Medicare Program Integrity	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 11859	**Date: February 16, 2023**
	Change Request 13061

SUBJECT: Eighth General Update to Provider Enrollment Instructions in Chapter 10 of CMS Publication (Pub.) 100-08

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to clarify several provider enrollment topics, including certain contractor referrals to CMS, sales agreements, and application processing clock stoppages.

EFFECTIVE DATE: March 17, 2023
**Unless otherwise specified, the effective date is the date of service.*

IMPLEMENTATION DATE: March 17, 2023
Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	10/10.1/Introduction to Medicare Provider Enrollment
R	10/10.1/10.1.4/General Overview of Medicare Enrollment Application Forms
R	10/10.2/10.2.1.3/End-Stage Renal Disease Facilities (ESRDs)
R	10/10.2/10.2.2.7/Pharmacies
R	10/10.2/10.2.3.16/Manufacturers of Replacement Parts/Supplies for Prosthetic Implants or Implantable Durable Medical Equipment (DME) Surgically Inserted at an Ambulatory Surgical Center (ASC)
R	10/10.4/10.4.8/Deactivations
R	10/10.5/Timeliness and Accuracy Standards
R	10/10.6/10.6.1.1.3.1.1/Special Processing Instructions and Considerations for the Initial Review Process
R	10/10.6/10.6.1.2/Changes of Information – Transitioned Certified Providers and Suppliers
R	10/10.6/10.6.21/Miscellaneous Enrollment Topics
R	10/10.6/10.6.22/Non-Transitioned Certified Provider/Supplier Changes of Ownership
R	10/10.6/10.6.22.1/Non-Transitioned Certified Provider/Supplier Changes of Information
R	10/10.6/10.6.23/Special Instructions for Electronic Funds Transfer (EFT) Accounts and Special Payment Addresses
R	10/10.7/Model Letters
R	10/10.7/10.7.7/Application Return and Rejection Model Letters
R	10/10.7/10.7.8/Denial Model Letters
R	10/10.7/10.7.9/Revocation Letters
R	10/10.7/10.7.12/Deactivation Model Letter
R	10/10.7/10.7.15/Revalidation Notification Letters

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: 11859	Date: February 16, 2023	Change Request: 13061

SUBJECT: Eighth General Update to Provider Enrollment Instructions in Chapter 10 of CMS Publication (Pub.) 100-08

EFFECTIVE DATE: March 17, 2023
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I. GENERAL INFORMATION

A. Background: Chapter 10 of Pub. 100-08 outlines policies related to Medicare provider enrollment and instructs contractors on the processing of Form CMS-855 provider enrollment applications. This CR clarifies several provider enrollment topics, including certain contractor communications with CMS, sales agreements, and application processing clock stoppages.

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

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
13061.1	The contractor shall, when applicable, adhere to the e-mail subject line requirements outlined in Section 10.6.21 in Chapter 10 of Pub. 100-08.	X	X	X						
13061.2	The contractor shall adhere to the EFT and special payment address instructions in Section 10.6.23 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. 11859; Issued: 02-16-23)

10.1 – Introduction to Medicare Provider Enrollment

(Rev. 11859; Issued: 02-16-23; Effective: 03-17-23; Implementation: 03-17-23)

This chapter specifies the resources and procedures Medicare Administrative Contractors (MAC*s*) must use to establish and maintain provider and supplier enrollment in the Medicare program. These procedures apply to the MACs (hereafter occasionally referred to collectively as simply "the contractor"), unless contract specifications state otherwise.

10.1.4 - General Overview of Medicare Enrollment Application Forms

(Rev. 11859; Issued: 02-16-23; Effective: 03-17-23; Implementation: 03-17-23)

The enrollment applications are available online as well as in paper form:

A. General Overview of Form CMS-855 and CMS-20134

Each Form CMS-855 application is used to enroll a specific provider or supplier type for a specific purpose.

1. CMS-855A – Medicare Enrollment Application for Institutional Providers

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

2. CMS-855B –Medicare Enrollment Application for Clinics, Group Practices, and Certain Other Suppliers

This application should be completed by supplier organizations (e.g., ambulance companies) that will bill Medicare for Part B services furnished to Medicare beneficiaries. It is not used to enroll individuals.

3. CMS-855I - Medicare Enrollment Application for Physicians and Non-Physician Practitioners

This application should be completed by physicians and non-physician practitioners who render Medicare Part B services to beneficiaries. (This includes a physician or practitioner who is: (1) the sole owner of a professional corporation, professional association, or limited liability company and will bill Medicare through this business entity; or (2) a sole proprietor.) (See section 10.6.4 of this chapter for more information on the business types discussed in this paragraph.)

4. CMS-855R - Medicare Enrollment Application for Reassignment of Medicare Benefits

An individual who renders Medicare Part B services and seeks to reassign his or her benefits to an eligible entity should complete this form for each entity eligible to receive reassigned benefits. The individual must be enrolled in the Medicare program as an individual prior to reassigning his or her benefits.

5. CMS-855S – Medicare Enrollment Application for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers

This application should be completed by DMEPOS suppliers.

6. CMS-855O – Medicare Enrollment Application for Eligible Ordering, Certifying Physicians, and other Eligible Professionals

This form is used for physicians and other eligible professionals who wish to register in Medicare solely for the purpose of ordering and certifying the items and services described in 42 CFR § 424.507. These physicians and other eligible professionals do not and will not send claims to a MAC for any services they furnish.

7. CMS-20134 – Medicare Enrollment Application for Medicare Diabetes Prevention Program (MDPP) Suppliers

This application should be completed by any supplier organizations that will furnish and bill Medicare Part B for the MDPP services furnished to Medicare beneficiaries.

B. General Overview of Additional Enrollment Forms

The following forms or form types are routinely submitted with an enrollment application:

1. CMS-588 – Electronic Funds Transfer (EFT) Authorization Agreement

The EFT Agreement authorizes CMS to deposit Medicare payments directly into a provider/supplier's bank account.

For Form CMS-855S enrollment*s*, CMS only requires collection of *the* Form CMS-588 with initial enrollment applications.

2. CMS-460 – Medicare Participating Physician or Supplier Agreement

This agreement establishes that the Medicare provider/supplier accepts assignment of the Medicare Part B payment for all services for which the participant is eligible to accept assignment under the Medicare law and regulations and which are furnished while the agreement is in effect. The contractor shall explain to the provider or supplier the purpose of the agreement and how it differs from the actual enrollment process. (This only applies to suppliers that complete the Forms CMS-855B, CMS-855I and CMS-855S.)

3. CMS Standard Electronic Data Interchange (EDI) Enrollment Form

See CMS Publication 100-04, Medicare Claims Processing Manual, chapter 24, sections 30 - 30.5 for further information.

4. State-Specific Forms for Certified Providers/Certified Suppliers

If the applicant is a certified supplier or certified provider, it will need to contact the state agency for any state-specific forms and to begin preparations for a state survey. (This does not apply to those certified entities, such as federally qualified health centers, that do not receive a state survey.)

10.2.1.3 - End-Stage Renal Disease Facilities (ESRDs)

(Rev. 11859; Issued: 02-16-23; Effective: 03-17-23; Implementation: 03-17-23)

(In this section 10.2.1.3, the terms "ESRD" and "ESRD facility" have the same meaning and will be used interchangeably).

A. General Background Information

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

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

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

B. Types of ESRD Facilities

Pub. 100-07, State Operations Manual, lists several classifications of ESRD facilities. They are summarized as follows:

1. Hospital-Based ESRD Facility

A hospital-based ESRD facility is a separately certified ESRD facility that (1) is an outpatient department of a hospital and (2) meets the ESRD conditions of coverage at 42 CFR Part 494. A hospital-based ESRD facility is owned and administered by a hospital or critical access hospital and is physically located on the hospital campus. If a hospital operates multiple separately certified hospital-based ESRD facilities, each separate ESRD facility must have its own CCN and be separately enrolled.

A hospital-based ESRD facility is discussed at 42 CFR § 413.174(c) and must meet the criteria listed therein (e.g., ESRD facility and hospital have a common governing body and are financially integrated). Hospital-based ESRD facilities are assigned CCNs from the 2300-2499 series.

2. Satellite Renal Dialysis Facility (Hospital-Based)

A satellite renal dialysis facility is a hospital-owned and hospital-administered ESRD facility but is not located on the campus of the hospital. A single hospital may have several satellite renal dialysis facilities. Each satellite facility: (1) is separately certified and surveyed; (2) must independently meet the ESRD conditions of coverage; (3) is assigned its own CCN; and (4) be separately enrolled. Satellite renal dialysis facilities (hospital-based) are assigned CCNs in the 3500-3699 series.

3. Independent Renal Dialysis Facility

An independent renal dialysis facility is any outpatient ESRD facility that does not meet the definition of a hospital-based renal dialysis facility or satellite renal dialysis facility as described in the paragraphs above. An independent renal dialysis facility may be physically located on a hospital campus, but it is not owned and/or administered by the hospital. Independent renal dialysis facilities are assigned CCNs in the 2500-2899 series and are individually enrolled.

4. Special Purpose Renal Dialysis Facility (SPRDF) (§ 494.120)

This type of renal disease facility is temporarily certified to furnish dialysis at special locations on a short-term basis (i.e., up to 8 months in any 12-month period) to a group of dialysis patients who would otherwise be unable to obtain treatment in the geographical area. The SOG Location must clearly specify the limited nature of the SPRDF certification, the time period covered by the certification, and the automatic termination of payment on the last day of the certification period in its notifications. The special locations for SPRDF fall into two categories:

(A) Vacation Camps - Vacation camps serve dialysis patients temporarily residing there. A vacation camp SPRDF would allow campers to receive hemodialysis at the camp site, avoiding interruption of the camping experience. Vacation camps may be approved for the duration of the camp but up to a maximum of 8 months in any 12-month period.

(B) Emergency Circumstance SPRDFs - These locations are set up to provide dialysis services to those ESRD patients who would otherwise be unable to obtain such services in their geographical area as a result of a natural or man-made disaster or a need for a greater capacity to dialyze patients who may have been evacuated from another location. The CMS SOG Location may extend the time period in emergency SPRDF approvals, where necessary, beyond the standard eight-month period based upon the termination of the emergency condition.

SPRDFs are assigned CCNs in the 3700-3799 series when owned and administered by a hospital and in the 2900-2999 series for independent facilities. Although they are individually enrolled, they cannot convert to a permanent ESRD facility (i.e., to a non-SPRDF). They must instead reapply as a brand new ESRD facility and receive an initial certification survey.

C. Processing Instructions for ESRD Initial Form CMS-855A Applications

An ESRD facility is separately and individually certified and does not have any branch, multiple, or parent locations. As such, each type of ESRD facility/location must independently and separately enroll as such via the Form CMS-855A; multiple sites cannot be listed on a single application.

Note that the instructions in this section 10.2.1.3(C) apply to all ESRD facility types except for SPRDFs. This ESRD type is not "transitioning" as that term is described in this chapter. Accordingly, the contractor shall continue to process initial applications from SPRDFs consistent with longstanding instructions rather than those described in this section 10.2.1.3(C) (e.g., receiving the final approval from the SOG location rather than the state; no need to send the application to PEOG after final SOG location approval).

1. Receipt of Application

Upon receipt of an initial ESRD Form CMS-855A application, the contractor shall undertake the following (in whichever order the contractor prefers unless directed otherwise in this chapter):

(A) Perform all data validations otherwise required per this chapter.

(B) Ensure that the application(s) is complete consistent with the instructions in this section 10.2.1.3 and this chapter.

(C) Ensure that the ESRD facility has submitted all documentation otherwise required per this chapter. For ESRD initial enrollment, this also includes the following:

- Evidence of successful electronic submission of the Form HHS-690 through the Office of Civil Rights (OCR) portal, as applicable. (Evidence should be either written or electronic documentation.) (See https://www.hhs.gov/sites/default/files/forms/hhs-690.pdf for more information.)

- Part I of the Form CMS-3427A (End Stage Renal Disease Application and Survey and Certification Report) (See Pub. 100-07, chapter 2, section 2247B for more information on this form.)

- A certificate of need (CON) if required by state law (though SPRDFs need not submit a CON)

(The ESRD must complete and submit Part I of the Form CMS-3427A, though the ESRD need not complete those sections of the form reserved for CMS. For organizational ESRDs, an authorized official (as defined in § 424.502) must sign the form; for sole proprietorships, the sole proprietor must sign. Note that there is no provider agreement for ESRD facilities*; the Form CMS-3427A is a survey and certification document, not a provider/supplier agreement.)*

Notwithstanding the foregoing, if the Form HHS-690, Part I of the Form-CMS-3427A, and/or CON evidence is missing, unsigned, undated, or otherwise incomplete, the contractor need not develop for the form(s) or the information thereon. (Nor need the contractor: (1) research individual state laws to ascertain whether the state requires a CON; or (2) review the data on the CON.) The contractor shall instead notify the state in its recommendation letter which document(s) was/were missing or otherwise incomplete. For all other missing or incomplete required documentation, the contractor shall follow the normal development instructions in this chapter.

2. Conclusion of Initial Contractor Review

(Nothing in this section 10.2.1.3(C) prohibits the contractor from returning or rejecting the ESRD application if otherwise permitted to do so per this chapter. When returning or rejecting the application, the contractor shall follow this chapter's procedures for doing so.)

(A) Approval Recommendation

If, consistent with the instructions in section 10.2.1.3(C) and this chapter, the contractor believes an approval recommendation is warranted, the contractor shall send the recommendation to the state pursuant to existing practice and this chapter's instructions. The contractor need not copy the SOG Location or PEOG on the recommendation. Unless CMS directs otherwise, the contractor shall also send to the provider the notification letter in section 10.7.5.1(E) of this chapter.

The state will: (1) review the recommendation package for completeness; (2) review the contractor's recommendation for approval; (3) perform any state-specific functions; and (4) contact the contractor with any questions. The contractor shall respond to any state inquiry in Item (4) within 5 business days. If the inquiry involves the need for the contractor to obtain additional data, documentation, or clarification from the ESRD, however, the timeframe is 15 business days; if the provider fails to respond to the contractor within this timeframe, it shall notify the state thereof. The contractor may always contact its PEOG BFL should it need the latter's assistance with a particular state inquiry.

(B) Denial

If the contractor determines that a denial is warranted, it shall follow the denial procedures outlined in this chapter. This includes: (1) using the appropriate denial letter format in section 10.7.5.1 of this chapter; and (2) if required under section 10.6.6 (or another CMS directive) of this chapter, referring the matter to PEOG for review prior to denying the application.

3. Completion of State Review

The state will notify the contractor once it has completed its review. There are two potential outcomes:

(A) Approval Not Recommended

If the state does not recommend approval, it will notify the contractor thereof----*typically via the Form CMS-1539, although the contractor* may accept any notification that is in writing (e-mail is fine). No later than 5 business days after receiving this notification, the contractor shall commence the actions described in section 10.2.1.3(C)(2)(B) above.

(B) Approval Recommended

If the state recommends approval, it will typically do so via a Form CMS-1539; however, the contractor may accept any documentation from the state signifying that the latter recommends approval. (Note that the contractor will not receive a formal tie-in notice.)

No later than 5 business days after receipt of the recommendation from the state, the contractor shall send an e-mail to MedicareProviderEnrollment@cms.hhs.gov with the following information and documents:

- The Form CMS-855 application (or PECOS Application Data Report) and all application attachments
- A copy of the Form CMS-1539 from the state or similar documentation received from the AO
- A copy of the draft approval letter, with the effective date shown on the Form CMS-1539 (or similar documentation) included in the draft letter. (See section 10.7.5.1 for the model approval letter.)

(As required per section 10.6.21 of this chapter, the e-mail subject line shall include the following: SUBJECT LINE: S&C: Facility Type; Application Type; Facility Name; National Provider Identifier; CCN; Application Receipt Date (MMDDYY) (*Date the Contractor Received the Application from the Provider/Supplier). (Note, however, that this data need not be duplicated in the e-mail's body.))*

PEOG will review the documentation. Based on the information received from the contractor, PEOG will also (1) assign an effective date, (2) assign a CCN, and (3) enter the relevant data into the applicable national database, and (4) approve (with possible edits) the approval letter. Within 5 business days of receiving from PEOG the effective date, and CCN the contractor shall: (1) send the approval letter to the ESRD provider, with a copy to the state and/or AO (as applicable); and (2) switch the PECOS record from "approval recommended" to "approved" consistent with existing instructions.

D. Additional/Changed Stations

If an enrolled ESRD seeks to add/change services or stations (e.g., add ESRD services in SNFs, additional modalities), the ESRD need not submit a Form CMS-855A application to do so, for these services and stations do not constitute practice locations and cannot otherwise be reported on the application. Instead, the ESRD contacts the state or accreditation organization (AO) to request these changes. The ESRD must complete a Form CMS-3427 and submit it to the state or AO (as applicable). A survey may be performed, and the state will update the applicable national database with any administrative changes.

The state will also send a CMS-1539 or approval letter to the contractor as notification of the additional/change service(s) or station(s). Consistent with longstanding practice, the contractor shall, as applicable, enter any relevant data on the CMS-1539/approval notice into its applicable system(s). (This may typically be needed for billing purposes.) No further action by the contractor is needed.

E. ESRD Location Changes

An ESRD facility that is changing its location must submit either a Form CMS-855A change of information application or an initial enrollment application. The specific transaction type involved (change request or initial) will depend on the particular situation. These situations include the following, and they will generally trigger the termination of the ESRD's existing CCN and the issuance of a new one.

(i) A hospital-based ESRD facility is relocating to an off-campus location in the same state.

In this situation, the ESRD's current CCN will be retired.

If the off-campus location will still function under a common governing body, operate under the hospital's policies and practices, continue to serve the same community, and utilize the same staff at this new location, the new CCN will be that of a renal satellite facility. The application can be processed as a change of information pursuant to the instructions in section 10.6.1.2(A).

If the off-campus location will no longer be operationally, administratively, or financially integrated with the hospital, the new CCN will be that of an independent dialysis facility. The hospital must voluntarily terminate this location from its enrollment, and the site must enroll as a new ESRD facility.

If the contractor has any questions as to whether the relocated location will still be sufficiently integrated with the hospital to permit a change of information application rather than an initial enrollment, the contractor may contact the state for guidance. The processing time clock stops while the contractor awaits the state's guidance.

(ii) An independent ESRD facility is relocating to become a hospital-based facility or a renal satellite facility of a hospital

Since the ESRD facility will be serving a different community under different policies, etc., the facility must terminate its existing enrollment and enroll as a new ESRD facility.

(iii) An independent ESRD facility is relocating to another location and will remain independent

If the ESRD facility will be serving a different community, the facility must terminate its existing enrollment and enroll as a new/initial ESRD facility. If it will serve the same community, the relocation can be processed as a change of information.

(iv) ESRD facility relocating out-of-state

If an ESRD facility of any type (e.g., independent, satellite) is relocating out-of-state --- and notwithstanding any other instruction to the contrary in this chapter ---- it must terminate its existing enrollment and enroll as an initial/new applicant.

F. CHOWs and Changes of Information

For ESRD CHOWs, the contractor shall follow the instructions in section 10.6.1.1 of this chapter. For ESRD changes of information, the contractor shall follow the instructions in section 10.6.1.2 of this chapter.

G. ESRD Survey and Certification

The standard CMS survey and certification form used for ESRDs is the Form CMS-3427. For more information on this form, see Pub. 100-07, chapter 2, section 2247B.

For further information on ESRD facilities, refer to:

- Section § 1881 of the Social Security Act
- 42 CFR Part 405, Subpart U
- Pub. 100-07, chapter 2, section 2270 – 2287B
- Pub. 100-02, chapter 11
- Pub. 100-04, Claims Processing Manual, chapter 8

10.2.2.7 – Pharmacies

(Rev. 11859; Issued: 02-16-23; Effective: 03-17-23; Implementation: 03-17-23)

Pharmacies are a supplier type that---depending upon the circumstances involved *and as discussed below*---enroll via the *Form CMS-855S or* Form CMS-855B.

A. General Background Information

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

B. Additional Information

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

- Pub. 100-04, chapter 17
- Pub. 100-02, chapter 15, sections 50 through 50.6

10.2.3.16 – Manufacturers of Replacement Parts/Supplies for Prosthetic Implants or Implantable Durable Medical Equipment (DME) Surgically Inserted at an Ambulatory Surgical Center (ASC)

(Rev. 11859; Issued: 02-16-23; Effective: 03-17-23; Implementation: 03-17-23)

Part A/B MACs make payments for implantable prosthetics and DME to hospitals, physicians, or ASC*s*. A manufacturer of non-implantable prosthetics and DME and replacement parts and supplies for prosthetic implants and surgically implantable DME may enroll in the Medicare program as a

DMEPOS supplier *via the Form CMS-855S* if it meets the definition of a supplier as well as the requirements of 42 CFR § 424.57.

10.4.8 – Deactivations

(Rev. 11859; Issued: 02-16-23; Effective: 03-17-23; Implementation: 03-17-23)

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:

(i) The provider/supplier fails to respond to a revalidation request.

(ii) The provider/supplier fails to respond timely to a revalidation development request.

(iii) The provider/supplier is enrolled in an approved status with neither an active reassignment nor practice location for 90 days or longer. (The deactivation basis shall be 42 CFR § 424.540(a)(4), which permits deactivation if the provider/supplier is not in compliance with all enrollment requirements. See sections 10.4.8(B) and (D) below for more information on this new deactivation ground.)

(iv) The provider/supplier deactivates an EFT agreement and remains enrolled but does not submit a new EFT agreement within 90 days. (The deactivation basis shall be 42 CFR § 424.540(a)(4).)

(v) The provider/supplier is deceased, and a situation arises where: (1) a particular instruction in this chapter calls for deactivation due to the provider's/supplier's death; and (2) said directive does not require obtaining PEOG approval prior to the deactivation. (See reference to 42 CFR § 424.540(a)(6) below.)

(vi) The provider or supplier is voluntarily withdrawing from Medicare, and a situation arises where: (1) a particular instruction in this chapter calls for deactivation due to the voluntary withdrawal; and (2) said directive does not require obtaining PEOG approval prior to the deactivation. (See reference to 42 CFR § 424.540(a)(7) below.)

(vii) The provider's or supplier's license has expired and the provider or supplier has not billed while the license was expired. (The deactivation basis shall be 42 CFR § 424.540(a)(4).)

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

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

1. Grounds

Section 424.540(a) lists eight 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 does not report a change to the information supplied on the enrollment application within the applicable time period required under Title 42. (For example, a provider/supplier type falling within the purview of § 424.516(e)(1) and

(2) failed to report a change in ownership or control within (i) 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.)

If the provider/supplier submits a change of information and (a) it appears the change was not reported within 90 days of the change, (b) the contractor did not previously take administrative action against the provider/supplier, and (c) 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) - The 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.

Section 424.540(a)(4) - The provider/supplier is not in compliance with all enrollment requirements. (See section 10.4.8(D) below for more information.)

Section 424.540(a)(5) - The provider's/supplier's practice location is non-operational or otherwise invalid. (See section 10.4.8(D) below for more information.)

Section 424.540(a)(6) - The provider/supplier is deceased.

Section 424.540(a)(7) - The provider/supplier is voluntarily withdrawing from Medicare.

Section 424.540(a)(8) - The provider is the seller in an HHA change of ownership under § 424.550(b)(1).

C. Effective Dates

(See § 424.540(d) for regulations concerning deactivation 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 in another CMS directive, the effective date is the date on which the deactivation is imposed.

b. Section 424.540(a)(2), (3), and (4) (see subsection (B) above) – Unless stated otherwise in this chapter or in another CMS directive, the effective date is the date on which the provider/ supplier became non-compliant (e.g., the day after the expiration of the 90-day period in which the provider was required to report a change of information).

c. Section 424.540(a)(5) – Unless stated otherwise in this chapter or in another CMS directive, the effective date is the date on which the provider's/supplier's practice location became non-operational or otherwise invalid.

d. Section 424.540(a)(6) - Unless stated otherwise in this chapter or in another CMS directive, the effective date is the date of death of the provider/supplier.

e. Section 424.540(a)(7) - Unless stated otherwise in this chapter or in another CMS directive, the effective date is the date on which the provider/supplier voluntarily withdrew from Medicare.

f. Section 424.540(a)(8) - Unless stated otherwise in this chapter or in another CMS directive, the effective date is the date of the sale. (Note that PEOG will ultimately determine this effective date during its review of the case per subsection (F) below.)

(See subsection 10.4.8(E) below for additional information on § 424.540(a)(7). See subsection 10.4.8(F) below for additional information on § 424.540(a)(8)).

D. Sections 424.540(a)(4) and (a)(5)

(This section 10.4.8(D) is inapplicable to the situations described in section 10.4.8(A)(iii) and (iv). These two scenarios do not require any referral to PEOG; the contractor can take deactivation action on its own volition.)
The grounds for deactivation under § 424.540(a)(4) and (a)(5) mirror the revocation reasons described in, respectively, § 424.535(a)(1) and (a)(5). When sending a potential § 424.535(a)(1) and (a)(5) revocation case to PEOG for review per section 10.4.7.1(A) of this chapter, PEOG will determine whether a revocation or a deactivation (under § 424.540(a)(4) or (a)(5)) is appropriate. The contractor shall not deactivate a provider or supplier under § 424.540(a)(4) or (a)(5) unless PEOG specifically directs the contractor to do so.

E. Section 424.540(a)(7)

See section 10.6.1.3 of this chapter for information regarding certified provider/supplier voluntary terminations and section 10.4.3(B) for information on non-certified supplier voluntary terminations.

F. Section 424.540(a)(8)

See section 10.2.1.6.1 of this chapter for information regarding seller CHOWs.

G. Miscellaneous

1. Except for deactivations under § 424.540(a)(8) (see § 424.550(b)(1)) and § 424.540(a)(7), the deactivation of Medicare billing privileges does not affect a provider/supplier's participation agreement.

2. 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 a deactivation due to failure to comply with a revalidation request.

3. Notwithstanding any other instruction to the contrary in this chapter, the provider/supplier may submit a rebuttal for deactivations imposed pursuant to § 424.540(a)(7) or (8). For these two rebuttal reasons, the contractor shall abide by the rebuttal policies in section 10.4.8.1. Note, however, that any such rebuttal only applies to the deactivation of billing privileges and not to the provider agreement termination.

10.5- Timeliness and Accuracy Standards

(Rev. 11859; Issued: 02-16-23; Effective: 03-17-23; Implementation: 03-17-23)

Sections 10.5(A) through 10.5(B)(4) of this chapter address the timeliness and accuracy standards applicable to the processing of Form CMS-855, Form CMS-20134 applications (initial and change of information and revalidation) and opt-out affidavits. Even though the provisions of 42 CFR §405.818 contain processing timeframes that differ than those in sections 10.5(A) through 10.5(B)(4), the contractor shall adhere to the standards specified in sections 10.5(A) through 10.5(B)(4).

The processing of an application or opt-out affidavit generally includes, but is not limited to, the following activities:

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

Note: The timeliness metrics discussed in this section are a combination of Part A applications and Part B applications and opt-out affidavits.

For purposes of Sections 10.5(A) and 10.5(B) below:

- The term "site visit" means that the provider or supplier requires an on-site review to determine that the provider or supplier is operational based on the type of provider or supplier.
- The term "development" means that the contractor needs to contact the provider or supplier for additional information; A development request (via letter, fax, email or telephone contact for development) to the provider or supplier is considered to be the first development request.
- The term "fingerprinting" means that 5 percent or greater owners or partners of a provider or supplier is required to submit fingerprints for an additional level of screening.

A. Standards for Initial and Change of Information Applications and Opt-Out Affidavits

For purposes of sections 10.5(A)(1) through 10.5(A)(4) of this chapter, the term "initial applications" also includes:

- Form CMS-855 or Form CMS-20134 change of ownership, acquisition/merger, and consolidation applications submitted by the new owner.
- "Complete" Form CMS-855 or Form CMS-20134 applications submitted by enrolled providers: (a) voluntarily, (b) as part of any change request if the provider does not have an established enrollment record in the Provider Enrollment, Chain and

Ownership System (PECOS), or (c) as a Form CMS- 855 or Form CMS-20134 reactivation.

- Opt-out affidavits submitted for an eligible practitioner's first opt-out period.

For purposes of sections 10.5(A)(1) through 10.5(A)(4) of this chapter, the term "changes of information" also includes:

- Form CMS-855 and Form CMS-20134 change of ownership, acquisition/merger, and consolidation applications submitted by the old owner
- Form CMS-588 changes submitted without a need for an accompanying complete Form CMS-855 or Form CMS-20134 application
- Form CMS-855R applications submitted independently (i.e., without being part of a Form CMS-855I or Form CMS-855B package)
- Form CMS-855 and Form CMS-20134 voluntary terminations
- Opt-out early termination requests (of initial opt-out affidavits), changes of information and cancellation requests

Initial and change of information application and opt-out timeliness standards shall be reported together. Likewise, initial, change of information and opt-out affidavit accuracy shall be reported together.

1. Paper Initial and Change of Information Applications and Opt-Out Affidavits - Timeliness

Please refer to Section 10.5 above for definitions of site visits, development and fingerprinting.

a. Form CMS-855 and Form CMS-20134 Initial and Change of Information Applications and Opt-Out Affidavits That Require a Site Visit, Development and/or Fingerprinting

The contractor shall process 95 percent of all Form CMS-855 and Form CMS- 20134 initial and change of information applications and opt-out affidavits (initial, changes of information, termination requests and cancellation requests) that require a site visit, development and/or fingerprinting within 65 calendar days of receipt and process 100 percent of all Form CMS-855 and Form CMS-20134 initial and change of information applications and opt-out affidavits (initial, changes of information, termination requests and cancellation requests) that require a site visit, development and/or fingerprinting within 100 calendar days of receipt.

b. Form CMS-855 and Form CMS-20134 Initial and Change of Information Applications and Opt-Out Affidavits That Do Not Require a Site Visit, Development and/or Fingerprinting

The contractor shall process 95 percent of all Form CMS-855 and Form CMS- 20134 initial and change of information applications and opt-out affidavits (initials, changes of information, termination and cancellation requests) that do not require a site visit, development and/or fingerprinting within 30 calendar days of receipt and process 100 percent of all Form CMS-855 and Form CMS-20134 initial and change of information applications and opt-out affidavits (initials, changes of information, termination and cancellation requests)

that do not require a site visit, development and/or fingerprinting within 65 calendar days of receipt.

2. Paper Initial and Change of Information Applications and Opt-Out Affidavits – Accuracy

The contractor shall process 98 percent of paper CMS-855 and Form CMS-20134 initial and change of information applications and opt-out affidavits in full accordance with all of the instructions in this chapter (with the exception of the timeliness standards identified in sections 10.5(A)(1) through 10.5(A)(2) of this chapter) and all other applicable CMS directives.

3. Web-Based Initial and Change of Information Applications - Timeliness

This process generally includes, but is not limited to verification of the application in accordance with existing instructions; requesting and receiving clarifying information in accordance with existing instructions; site visit (ifrequired) and/or requesting fingerprints (if necessary). Please refer to Section 10.5 above for definitions of site visits, development and fingerprinting.

a. Web-Based Initial and Change of Information Applications That Require a Site Visit, Development and/or Fingerprinting

The contractor shall process 95 percent of all Form CMS-855 and Form CMS- 20134 Web-based initial and change of information applications that require a site visit, development and/or fingerprinting within 50 calendar days of receipt and process 100 percent of all Form CMS-855 and Form CMS-20134 Web-based initial and change of information applications that require a site visit, development and/or fingerprinting within 85 calendar days of receipt.

b. Web-Based Initial and Change of Information Applications That Do Not Require a Site Visit, Development and/or Fingerprinting

The contractor shall process 95 percent of Form CMS-855 and Form CMS-20134 Web-based initial and change of information applications that do not require a site visit, development and/or fingerprinting within 15 calendar days of receipt and process 100 percent of Form CMS-855 and Form CMS-20134 Web-based initial and change of information applications that do not require a site visit, development and/or fingerprinting within 50 calendar days of receipt.

4. Web-Based Initial and Change of Information Applications - Accuracy

The contractor shall process 98 percent of Form CMS-855 and Form CMS-20134 Web-based initial and change of information applications in full accordance with all of the instructions in this chapter (with the exception of the timeliness standards identified in section 10.5(A)(3) above) and all other applicable CMS directives.

B. Standards for Revalidation Applications

For purposes of sections 10.5(B)(1) through 10.5(B)(3)(b) of this chapter, the term "revalidation applications" includes complete Form CMS-855 or Form CMS-20134 revalidation applications submitted by enrolled providers.

1. Paper Revalidation Applications that Require Site Visits, Development and/or Fingerprinting - Timeliness

Please refer to Section 10.5 above for definitions of site visits, development and fingerprinting.

a. Form CMS-855 and Form CMS-20134 Revalidation Applications That Require a Site Visit, Development and/or Fingerprinting – Timeliness

The contractor shall process 80 percent of paper Form CMS-855 and Form CMS- 20134 revalidation applications that require site visits, development and/or fingerprinting within 65 calendar days of receipt and process 100 percent of paper Form CMS-855 and Form CMS-20134 revalidation applications within 100 calendar days of receipt.

b. Paper Revalidation Applications that do not Require Site Visits, Development and/or Fingerprinting - Timeliness

The contractor shall process 80 percent of paper Form CMS-855 and Form CMS- 20134 revalidation applications that do not require site visits, development and/or fingerprinting within 30 calendar days of receipt and process 100 percent of paper Form CMS-855 and Form CMS-20134 revalidation applications within 65 calendar days of receipt.

2. Paper Revalidation Applications - Accuracy

The contractor shall process 98 percent of paper Form CMS-855 and Form CMS-20134 revalidations in full accordance with all of the instructions in this chapter (with the exception of the timeliness standards identified in section 10.5(B)(1) above) and all other applicable CMS directives.

3. Web-Based Revalidation Applications - Timeliness

This process generally includes, but is not limited to verification of the application in accordance with existing instructions; requesting and receiving clarifying information in accordance with existing instructions; site visit (ifrequired) and/or requesting fingerprints (if necessary). Please refer to Section 10.5 above for definitions of site visits, development and fingerprinting.

a. Web-Based Revalidation Applications That Require a Site Visit, Development and/or Fingerprinting - Timeliness

The contractor shall process 80 percent of all Form CMS-855 and Form CMS- 20134 Web-based revalidation applications that require a site visit, development and/or fingerprinting within 50 calendar days of receipt and process 100 percent of all Form CMS-855 and Form CMS-20134 Web-based revalidation applications that require a site visit, development and/or fingerprinting within 85 calendar days of receipt.

b. Web-Based Revalidation Applications That Do Not Require a Site Visit, Development and/or Fingerprinting - Timeliness

The contractor shall process 80 percent of Form CMS-855 and Form CMS-20134 Web-based revalidation applications that do not require a site visit, development and/or fingerprinting within 15 calendar days of receipt and process 100 percent of Form CMS-855 and Form CMS-20134 Web-based revalidation applications that do not require a site visit, development and/or fingerprinting within 50 calendar days of receipt.

4. Web-Based Revalidation Applications - Accuracy

The contractor shall process 98 percent of Form CMS-855 and Form CMS-20134 Web-based revalidation applications in full accordance with all of the instructions in this chapter (with the exception of the timeliness standards identified in sections 10.5(B)(1) and 10.5(B)(3)(b) above) and all other applicable CMS directives.

C. General Timeliness Principles

Unless stated otherwise in this chapter or in another CMS directive, the principles discussed below apply to all applications discussed in sections 10.5(A)(1) through 10.5(B)(3) of this chapter (e.g., change of ownership (CHOW) applications submitted by old and new owners, CMS-588 forms).

1. Clock Stoppages

The processing timeliness clock temporarily stops when the situations identified in section 10.5(C)(1) occur:

- Referring an application to the Office of Inspector General (OIG) or the Unified Program Integrity Contractor (UPIC).
- Waiting for a final sales agreement (e.g., CHOW, acquisition/merger).
- Contacting the *CMS Location* and/or State Agency (SA) regarding a provider-based or CHOW determination or the *CMS Location*'s survey and certification staff with a question regarding the application of a CMS policy.
- Referring a provider or supplier to update their information in the National Plan & Provider Enumeration System.
- Contacting CMS' Provider Enrollment & Oversight Group (PEOG) for the following reasons: questions regarding the application, *a* CMS policy, an *a*dverse *l*egal *a*ction review, affiliations/overpayments found on the monthly report or PECOS, Advanced Provider Screening criminal alerts, or delayed site visits.
- Referring a provider to the Social Security Administration to resolve a discrepancy involving a social security number or to the Internal Revenue Service to resolve a Tax Identification Number or Individual Tax Identification Number issue.
- Contact*ing* another MAC for any type of PECOS update (i.e.: locked associates).
- Contact*ing* the PECOS Maintainer for resolutions to system issues (i.e.: RightNow tickets).
- *Contacting the state licensing board to verify a license or to obtain board order documentation.*
- Practice location and Special Payment address changes and specialty changes with future dates.
- If fingerprints are required, the timeliness clock stops when the fingerprint request is issued and resumes when the contractor receives the results (if additional information is developed at the same time as the fingerprint request is issued, no action shall be taken on the developed information until after the fingerprint results are received).

- *Situations can arise where the provider/supplier submits an Internet-based PECOS application and makes edits to it before all signatures are received. This can lock the PECOS Logging and Tracking (L&T), thus preventing the contractor from beginning to process the application until the application is resubmitted. The contractor in this specific situation may apply a clock stoppage between the time the L & T is locked and the time it is unlocked (i.e., the application is submitted). (Note that this instruction may be rendered moot with the implementation of PECOS 2.0.)*

Should a dependent application be needed to continue processing (for example: a CMS-855R is needed to complete a reassignment when only a CMS-855I is received), *the* contractor shall apply a clock stoppage when the development is issued and resume the timeliness clock once the development is received.

The contractor should always document any delays by identifying when the referral to CMS, the OIG, etc., was made, the reason for the referral, and when a response was received. By doing so, the contractor will be able to furnish explanatory documentation to CMS should applicable time limits be exceeded. To illustrate, assume that a contractor received an initial Form CMS-855I application on March 1. On March 30, the contractor sent a question to CMS, and received a reply on April 7. The processing time clock stops from March 31 to April 7. The contractor should document its files to explain that it forwarded the question to CMS, the dates involved, and the reason for the referral.

2. Calendar Days

Unless otherwise stated in this chapter, all days in the processing time clock are "calendar" days, not "business days." If the final day of a metric falls on a weekend or holiday, this is still the day by which the application must be processed. If the contractor is unable to finish processing the application until the next business day, it should document the file that the final day of the metric fell on a Saturday/Sunday/holiday and furnish any additional explanation as needed.

3. Date-Stamping

As a general rule, all incoming correspondence must be date-stamped on the day it was received in the contractor's mailroom. This includes, but is not limited to:

- Any Form CMS-855 or Form CMS-20134 application, including initials, changes, CHOWs, etc. (The first page of the application must be date-stamped.)

- Letters from providers. (The first page of the letter must be date-stamped.)

- Supporting documentation, such as licenses, certifications, articles of incorporation, and billing agreements. (The first page of the document or the envelope must be date-stamped.)

- Data that the provider furnishes (via mail or fax) per the contractor's request for additional information. (All submitted pages must be date-stamped. This is because many contractors interleaf the new/changed pages within the original application. Thus, it is necessary to determine the sequence in which the application and the additional pages were received.)

Note: applications received via Internet-Based PECOS are considered "date stamped" on the date the application was received, which is reflected as part of the applications' L&T ID.

The timeliness clock begins on the date on which the application/envelope is date-stamped in the contractor's mailroom, not the date on which the application is date-stamped or received by the provider enrollment unit. As such, the date-stamping activities described in the above bullets must be performed in the contractor's mailroom. In cases where the mailroom staff fails to date-stamp a particular document, the provider enrollment unit may date-stamp the page in question. However, there shall not be long lapses between the time it was received in the mailroom and the time the provider enrollment unit date-stamped the pages.

In addition, and unless stated otherwise in this chapter or in another CMS directive, all incoming enrollment applications (including change requests) must be submitted via mail (unless circumstances require submission via fax or email, as noted in Section 10.4(D)(6)(a) of this chapter).

4. When the Processing Cycle Ends

For (1) Form CMS-855A applications, and (2) Form CMS-855B applications submitted by ambulatory surgical centers (ASCs) or portable x-ray suppliers, the processing cycle ends on the date that the contractor enters a final status (approval or denial recommended) in PECOS, rather than the date that the contractor sends formal notification to the SA or CMS RO of the contractor's approval, denial or recommendation for approval of the application (note that accompanying applications, such as CMS-855R applications submitted along with a CMS-855B for an ASC, would also end their processing cycle).

In situations involving a change request that does not require a recommendation (i.e., it need not be forwarded to and approved by the State or RO), the cycle ends on the date that the contractor enters a final status (approved, denied, rejected, returned, etc.) in PECOS.

For (1) Form CMS-855I applications, (2) Form CMS-855R applications, (3) Form CMS-855B applications from suppliers other than ASCs and portable x-ray suppliers, (4) Form CMS-20134 and (5) Form CMS-855S applications the processing cycle ends on the date that the contractor enters a final status (approved, denied, rejected, returned, etc.) in PECOS.

5. PECOS

The contractor may begin the verification process at any time. Also, the contractor is not required to create a PECOS (L&T at any specific time, though an L&T record must be created in order to enter and finalize the application in PECOS.

Moreover, the contractor must establish a complete enrollment record in PECOS prior to its approval, recommendation of approval, or denial of the provider's application. To the maximum extent possible, the contractor shall establish the enrollment record at one time, rather than on a piecemeal basis.

10.6.1.1.3.1.1 – Special Processing Instructions and Considerations for the Initial Review Process

(Rev. 11859; Issued: 02-16-23; Effective: 03-17-23; Implementation: 03-17-23)

A. Form CMS-855A – Old and New Owner Applications

Unless stated otherwise in this chapter:

- The contractor shall ensure that all applicable sections of the Form CMS-855A for both the old and new owner are completed in accordance with the instructions on the Form CMS-855A.

- The instructions in this section 10.6.1.1.3.1.1(A) apply only to the Form CMS-855A.

1. Previous Owner(s)

The previous owner's Form CMS-855A CHOW application does not require a recommendation for approval. Any recommendations will be based on the CHOW application received from the new owner.

If the previous owner's Form CMS-855A is available at the time of review, the contractor shall examine the information therein against the new owner's Form CMS-855A to ensure consistency (e.g., same names). If the previous owner's Form CMS-855A has not been received, the contractor shall contact the previous owner and request it. However, the contractor may begin processing the new owner's application without waiting for the arrival of the previous owner's application. It may also make its CHOW recommendation to the state without having received the previous owner's Form CMS-855A.

If a certification statement is not on file for the individual signing the previous owner's application, the contractor shall request that the Individual Ownership and/or Managing Control section of the Form CMS-855A be completed for said person.

Note that the previous owner's Form CMS-855A CHOW application is essentially the equivalent of a Form CMS-855A voluntary termination submission; this is because the old owner is voluntarily leaving the Medicare program. As such, the contractor shall not require the old owner to submit a separate Form CMS-855A voluntary termination along with its Form CMS-855A CHOW application.

2. New Owner

If a Form CMS-855A is not received from the new owner within 14 calendar days of receipt of the old owner's Form CMS-855A, the contractor shall contact the new owner. If, within 30 calendar days after the contractor contacted it, the new owner fails to (1) submit a Form CMS-855A and (2) indicate that it accepts assignment of the provider agreement, the contractor shall send an e-mail to its PEOG BFL notifying him/her of the situation. PEOG will determine whether the provider's billing privileges should be deactivated under § 424.540(a)(2) or § 424.550(b) or revoked under § 424.535(a)(1) or (a)(9). PEOG will notify the contractor of its decision.

In the situations described in the previous paragraph where the contractor is awaiting the new owner's application after received the old owner's, the contractor shall: (1) begin processing the old owner's application; and (2) if possible, ascertain whether a CHOW has taken place.

3. Order of Processing of Old/New Owner Applications

To the maximum extent practicable, Form CMS-855A applications from the previous and new owners in a CHOW should be processed as they arrive. However, unless the instructions in this chapter indicate otherwise, the contractor should attempt to send the previous and new owners' applications to the state simultaneously, rather than as soon as they are processed. For instance, suppose the previous owner submits an application on March 1. The contractor should begin processing the application immediately without waiting for the arrival of the new owner's application. Yet the contractor should avoid sending the previous owner's application to the state until the new owner's application is processed. (For acquisition/mergers and consolidations (as those terms are described on the Form CMS-855A), the contractor may send the applications to the state separately.)

4. Form CMS-855A: CHOWs Involving Subtypes

a. Separate Reporting

Any subunit that has a separate provider agreement must report its CHOW on a separate Form CMS-855A. It cannot report the CHOW via the main provider's Form CMS-855A. If the subunit does not have a separate provider agreement (e.g., hospital psychiatric unit), the CHOW can be disclosed on the main provider's Form CMS-855A; this is because the subunit is a practice location of the main provider and not a separately enrolled entity.

b. Change in Subtype

A CHOW may occur in union with a change in the facility's provider subtype. This can happen, for instance, when a hospital undergoes a CHOW and changes from a general hospital to another type of hospital, such as a psychiatric hospital. Although a change in hospital type is considered a change of information (COI), the provider need not submit separate applications – one for the COI and one for the CHOW. Instead, all information (including the change in hospital type) should be reported on the CHOW application; the entire application should then be processed as a CHOW (assuming it indeed qualifies as such). However, if the facility is changing from one main provider type to another (e.g., hospital converting to a skilled nursing facility) and also undergoing a CHOW, the provider must submit its application as an initial enrollment. The contractor shall notify the provider of this and return the application.

(NOTE: For Medicare purposes, a critical access hospital (CAH) is a separately-recognized provider type. Thus, a general hospital undergoing a CHOW while converting to a CAH must submit its Form CMS-855A as an initial enrollment, not as a CHOW.)

5. Transitioning to Provider-Based Status (Form CMS-855A Submissions Only)

Consistent with existing CMS policy, a provider undergoing a CHOW pursuant to 42 CFR § 489.18 may be assigned to a new contractor jurisdiction only if the provider is transitioning from freestanding to provider-based status. In such cases, the contractor for the new jurisdiction (the "new contractor") shall process both the old and new owner's Form CMS-855A applications. Should the "old/previous" (or current) contractor receive the old and/or new owner's Form CMS-855A applications, it shall (a) forward the application to the new contractor within 5 business days of receipt and (b) notify the new contractor within that same timeframe that the application was sent.

B. Sales and Lease Agreements

Except as indicated otherwise, this subsection (B) applies to Form CMS-855A and Form CMS-855B applications.

1. Verification of Terms

The contractor shall ascertain whether: (1) the sales/lease agreement includes the signatures of the old and new owners*, for the agreement must contain the signatures of both parties to the transaction (if it does not, the contractor shall develop for an agreement containing both signatures)*; (2) the information contained in the sales agreement is consistent with that reported on the new owner's Form CMS-855A or the submitted Form CMS-855B (e.g., same names, effective date); (3) the terms of the contract indicate that the new owner will accept assignment of the provider agreement; and (4) the transaction falls within the scope of organizational transactions covered under § 489.18 and this section 10.6.1.1 et seq.

(Note that a bill of sale/lease agreement/sales transfer agreement is a sales/lease business document and should not be confused with a patient transfer agreement.)

A sales/lease agreement often will not specifically refer to the Medicare provider agreement, assets, and liabilities. However, if (1) the box in the Change of Ownership (CHOW) Information section of the Form CMS-855A is checked "Yes" and (2) the sales/lease agreement either confirms that the new owner will accept assignment or is relatively silent on the matter, the contractor can proceed as normal. If the agreement indicates that assignment will not be accepted, however, the contractor shall follow the instructions in section 10.6.1.1.3.2(A) below.

As previously mentioned, any clarifying data must be furnished in writing (e.g., additional legal documentation, letter, e-mail). If the clarification – for whatever reason - requires an update to the supplier's Form CMS-855 application, the contractor shall request the submission of said update. In addition, if the contractor discovers discrepancies between the data in the sales agreement and that on the Form CMS-855, the contractor shall seek clarifying information and, if necessary, obtain an updated Form CMS-855.

2. Form of Sales/Lease Agreement

There are instances where the parties in a CHOW did not sign a "sales" or "lease" agreement in the conventional sense of the term; the parties, for example, might have documented their agreement via a "bill of sale." The contractor can accept such documentation in lieu of a sales/lease agreement so long as (1) the document addresses the transaction's terms and (2) the information in the agreement is consistent with that on the Form CMS-855 (as discussed above).

3. Submission of Sales/Lease Agreement

a. General Requirements – Unless specified otherwise in this chapter: (i) both the previous and new owners in a Form CMS-855A CHOW situation must submit copies of the interim and final sales/lease agreements; and (ii) copies of the interim and final sales/lease agreement must be submitted in Form CMS-855B CHOW situations.

b. Forwarding to State - The contractor shall not forward a copy of the application to the state until it has received and reviewed the final sales/lease agreement. However, the contractor need not reverify the information on the Form CMS-855 while waiting for the final agreement, even if the data therein may be somewhat outdated by the time the final agreement is received.

c. Failure to Submit - If a final sales/lease agreement is not submitted within 30 days after the contractor's receipt of the new owner's application, the contractor shall reject the application. Though the contractor must wait until the 30th day to reject the application, the contractor may proceed with rejection regardless of how many times it contacted the new owner or what types of responses (short of the actual receipt of the agreement) were received.

C. Relocation of Entity

A new owner may intend to relocate the provider concurrent with a CHOW. If the relocation is to a site in a different geographic area serving different clients than previously served and employing different personnel to serve those clients, the contractor shall notify the state via e-mail immediately. If the state believes that this situation has resulted in the effective creation of a new provider, the contractor shall return the application and notify the new owner that a new, initial enrollment application must be submitted. The provider must also notify the state or, if applicable, accreditation agency.

D. Intervening Change of Ownership

In situations where the provider (1) submits a Form CMS-855 initial application or CHOW application and (2) subsequently submits a Form CMS-855 CHOW application before the contractor has finalized the first application, the contractor shall adhere to the following:

Situation 1 – The provider submitted an initial application followed by a CHOW application, and a recommendation for approval to the state has not yet been made for the initial application: The contractor shall return both applications and require the provider to re-submit an initial application with the new owner's information.

Situation 2 - The provider submitted a CHOW application followed by another CHOW application, and a recommendation for approval to the state has not yet been made for the first CHOW application: The contractor shall process both applications – preferably in the order they were received – and shall, if recommendations for approval are warranted, refer both applications to the state in the same package. The accompanying notice/letter to the state shall explain the situation.

Situation 3 - The provider submitted an initial application followed by a CHOW application, and a recommendation for approval of the initial application has been made to the state – The contractor shall:

- Return the CHOW application.

- Notify the state via e-mail that a change of ownership has occurred (the new owner should be identified) and that the contractor will require the new provider to resubmit a new initial application containing the new owner's information.

- Request via letter that the provider submit a new initial Form CMS-855 application containing the new owner's information within 30 days of the date of the letter. If the provider fails to do so, the contractor shall return the originally submitted initial application and notify the provider and the state of this via letter. If the provider submits the requested application, the contractor shall process it as normal and, if a recommendation for approval is made, send the revised application package to the state with an explanation of the situation; the originally submitted initial application becomes moot. If the newly submitted/second initial application is denied, however, the first submitted application is denied as well; the contractor shall notify the provider and the state accordingly.

Situation 4 - The provider submitted a CHOW application followed by another CHOW application, and a recommendation for approval has been made for the first application - The contractor shall:

- Notify the state via e-mail that (1) a subsequent change of ownership has occurred (the new owner should be identified) and (2) the contractor will require the provider to resubmit a new CHOW application containing the subsequent/second new owner's information.

- Process the new/second CHOW application as normal. If a recommendation for approval is made, the contractor shall send the revised CHOW package to the state with an explanation of the situation; the first CHOW application becomes moot. If the newly submitted/second CHOW application is returned per section 10.6.1.1.3.2 below, the first application should, too, be returned. The contractor shall notify the provider and the state accordingly.

***E*. Potential CHOW**

On occasion, a provider or supplier submits a Form CMS-855 change of information to report a large-scale stock transfer or other significant ownership change that the provider does not believe is (or report as) a CHOW. If the contractor suspects that the transaction in question might indeed be a CHOW, it shall request clarifying information (e.g., copy of the stock transfer agreement).

F. Entry into PECOS

If it appears that the new owner will be accepting assignment and that the transaction falls within the scope of § 489.18, the contractor shall enter the CHOW information into the new enrollment record that shall be created for the new owner. (If the state recommends approval of the CHOW (see section 10.6.1.1.3.3 below), the Part A provider's CCN will be maintained in the new owner's enrollment record once the record is switched to an approved status.)

A new enrollment record must be created if a new TIN is established pursuant to the CHOW.

10.6.1.2 – Changes of Information – Transitioned Certified Providers and Suppliers

(Rev. 11859; Issued: 02-16-23; Effective: 03-17-23; Implementation: 03-17-23)

(Until further notice from CMS, the instructions in this section 10.6.1.2 apply only to certified provider and certified supplier types that have officially "transitioned" as part of the transition of various certification activities from the SOG Location to the states, the contractors, and PEOG. These provider/supplier types include SNFs, HHAs, CMHCs, CORFs, FQHCs, Part A OPT/OSP providers, ASCs, PXRSs, hospitals, hospices, and ESRD facilities. The contractor shall continue to use the existing change of information instructions--now in section 10.6.22.1 of this chapter--for all non-transitioned certified provider/supplier types.

When executing the instructions in this section 10.6.1.2, the contractor can disregard directives that obviously do not apply to the transitioned provider/supplier type in question (e.g., references to hospitals).

All references to the SOG Location (formerly the "RO") in this section 10.6.1.2 refer to the applicable CMS Regional Office's Survey & Operations Group (SOG) Location. Also, and except as otherwise indicated, all references to "provider" include certified suppliers (e.g., ambulatory surgical centers, portable x-ray suppliers).

The instructions in this section 10.6.1.2 address the handling of changes of information involving certified providers and certified suppliers. With the transition of certain functions from the SOG Locations to the contractors and the Provider Enrollment & Oversight Group (PEOG), the processing instructions for these changes of information are slightly different from previous guidance. In particular: (1) the SOG Locations will be much less involved in the process; (2) tie-in and tie-out notices will no longer be issued; (3) the contractor will be responsible for finalizing changes previously requiring SOG Location approval; and (4) recommendations of approval will be made to (and reviewed by) the state agency (hereafter occasionally referenced simply as "state") only and not the SOG Location.

Except as stated otherwise:

(1) Any provider-specific instructions in section 10.2.1 et seq. of this chapter pertaining to changes of information (e.g., relocation of a federally qualified health clinic site) take precedence over those in this section 10.6.1.2.

(2) Any instructions pertaining to ownership changes in section 10.6.1.1 et seq. of this chapter take precedence over those in this section 10.6.1.2.

(3) Any instructions pertaining to voluntary terminations of entire enrollments and/or provider agreements in section 10.6.1.3 of this chapter take precedence over those in this section 10.6.1.2.

(4) Any instructions in this section 10.6.1.2 concerning the voluntary termination of a branch, sub-unit, or other practice location that does not involve the termination of the entire enrollment and/or provider agreement take precedence over those in section 10.6.1.3. For instance, suppose a certified provider's Form CMS-855A enrollment has three practice locations and/or sub-units. The provider is voluntarily terminating one of them. Here, the contractor shall use the instructions in section 10.6.1.2 when processing this transaction. Now assume that a provider is of a type that must individually and separately enroll each location. The provider has three separately enrolled locations with three separate provider agreements. The provider seeks to terminate one of these locations. Since this will involve the termination of an individual/entire enrollment and corresponding provider agreement, the instructions in section 10.6.1.3 apply.

A. Changes of Information Requiring Recommendation to the State

1. Types

The following Form CMS-855 transactions require an approval recommendation to (and review by) the state prior to approval:

- Addition of outpatient physical therapy/outpatient speech pathology extension site
- Addition of HHA branch
- Addition or deletion of a prospective payment system (PPS)-excluded psychiatric unit, rehabilitation unit, or transplant program
- Addition or deletion of swing-bed approval (see Section 2A2 of the Form CMS-855A)
- Conversion of a hospital from one type to another (e.g., acute care to psychiatric)
- Addition, deletion, or relocation of a hospice practice location
- Addition, change, and/or relocation of a hospital practice location when a survey of the new site may be required. (If the contractor is uncertain as to whether the state will perform a survey, it may (1) contact the state for guidance or (2) make the referral based on the contractor's experience with these types of changes and with the practices of the state in question. Note that a survey often may be required if the location is shifting outside of the existing geographic area.)
- Addition of PXRS practice location

2. Initial Contractor Review and Recommendation

The contractor shall process the change request consistent with the instructions in this chapter (e.g., verification of data, developing for missing or conflicting data). If the contractor determines that the change/addition should be approved, it shall send the appropriate recommendation letter (see section 10.7 et seq.) to the state with all applicable documentation

that the contractor currently sends in such situations. The SOG Location need not be copied on the letter.

Nothing in this section 10.6.1.2(A)(2):

- Prohibits the contractor from returning or rejecting the application if grounds for doing so exist.
- Supersedes any applicable requirement for performing a site visit (including the timing of such visits).

3. State Review and Contractor Receipt of Recommendation

The state will review the recommendation of approval, the application, and any other pertinent information. If the state decides to perform a survey, it will do so and notify the contractor thereof.

a. State Recommends Approval

If the state concludes that the change/addition should be approved, it will make a recommendation to this effect to the contractor, typically via a Form CMS-1539 and/or similar confirming documentation. No later than 5 business days after receipt of the recommendation, the contractor shall send an e-mail to MedicareProviderEnrollment@cms.hhs.gov containing general identifying data about the provider (including LBN, specialty, facility address), a copy of the Form CMS-1539 (or other similar documentation evidencing the state's approval recommendation, if available), the draft provider approval letter, and a description of the change to be made. *The e-mail subject line shall include the following: SUBJECT LINE: S&C: Facility Type; Application Type; Facility Name; National Provider Identifier; CCN; Application Receipt Date (MMDDYY*) (*Date the Contractor Received the Application from the Provider/Supplier). (Note that the data in the subject line need not be repeated in the e-mail body.)*

If, to the contractor's knowledge, a new CCN is required, the name and address of the new entity requiring the CCN should be furnished along with the effective date. If a termination is involved (e.g., HHA branch), the contractor shall include the old CCN and the termination date in the e-mail.

Once PEOG responds to the contractor, the latter may finalize its processing of the application (e.g., sending copies of the provider notification of approval to the state and, if applicable, accrediting organization; switching the PECOS record from "approval recommended" to "approved").

b. State Does Not Recommend Approval

If the state does not recommend approval, the contractor shall refer the matter to MedicareProviderEnrollment@cms.hhs.gov for guidance. The e-mail to him/her shall contain *(i)* the identifying data *as* described in (3)(a) above *(including a copy of the draft denial letter)*; *(ii) the e-mail subject line data as described in (3)(a) above and in section 10.6.21*; *(iii)* a copy of the notification from the state *(e.g., Form CMS-1539)* declining to recommend approval; and *(iv)* any other information the contractor deems pertinent. PEOG will review the matter and furnish the contractor additional instructions. *Once PEOG's review is completed---and absent any PEOG directive to the contrary---the contractor shall follow the denial procedures outlined in this chapter. This includes sending the denial letter to the provider/supplier and, if/as required per this chapter, a copy to the state and/or accrediting organization.*

4. Additional Policies

a. Post-Recommendation Inquiries - Once the contractor has made its recommendation for approval to the state, any inquiry the contractor receives from the provider regarding the status of its change request shall be referred to the state.

***b*. State Practice -** The PECOS record should not be switched to "Approved" until the contractor receives the state's approval recommendation. However, if the contractor knows that the state in question generally does not review this type of transaction, the contractor need not send the transaction to the state and shall instead follow the instructions in section 10.6.1.2(B) below.

B. Post-Approval State Notification Required

1. Post-Approval Correspondence

Form CMS-855 changes that do not mandate a recommendation to the state but do require post-approval correspondence with the state (and, if applicable, the accrediting organization) include:

(i) Except as described in section 10.6.1.2(A), deletions/voluntary terminations of practice locations or hospital subunits. (Note that this scenario is different from cases where the provider is voluntary terminating its enrollment as a whole (per section 10.6.1.3 of this chapter) rather than simply terminating a single location or subunit within its enrollment.)

(ii) LBN, TIN, or "doing business as name" changes that do not involve a CHOW

(iii) Except as described in section 10.6.1.2(A), address changes that generally do not require a survey of the new location

(iv) Addition, change, and/or relocation of a hospital practice location for which a survey is not required. *(For purposes of this requirement only, the term "hospital practice location" does not include hospital physician/practitioner group practice locations. Additions/changes/relocations of such locations do not require post-approval notification to the state or AO.)*

(v) Ownership changes that involve neither a 42 CFR § 489.18 CHOW nor a § 424.550(b) exempt or non-exempt change in HHA majority ownership (e.g., a 15 percent owner of a hospice sells her ownership stake).

No post-approval correspondence with PEOG is necessary in situations (ii) through (v) above.
For situation (i), correspondence with PEOG is only required if the deletion involves the termination of a CCN and subsequent update of ASPEN (e.g., deletion of hospital sub-unit).

The contractor shall:

(1) Inform the state and the AO (if appropriate) of the changed information (via any mechanism it chooses, including copying the state/AO on the notification letter or e-mail to the provider) no later than 10 calendar days after it has completed processing the transaction. Such notice to the state/AO shall specify the type of information that is changing. (Prior PEOG approval of the change is not required, though PEOG will update applicable national database as needed *(see situation (B)(1)(i) above)).*

(2) Switch the PECOS record to "Approved."

C. All Other Changes of Information

1. General Principle

For all Form CMS-855 change requests not identified in section 10.6.1.2(A)(1) and (B) above (and except as stated in subsection (C)(2) below), the contractor shall: (1) notify the provider via letter, fax, e-mail, or telephone that the change has been made; and (2) switch the PECOS record to "Approved." The contractor need not notify the state, SOG Location, or PEOG of the change.

2. FQHCs

If an FQHC is adding, deleting, or changing a Section 13 contact person , the contractor shall send an approval letter via e-mail and copy the MedicareProviderEnrollment@cms.hhs.gov mailbox (with "FQHC COI" in the subject line) thereon. (Aside from this exception, all other instructions in subsection (C)(1) apply to this scenario.) See section 10.2.1.4(D) of this chapter for more information on FQHC changes of information.

D. Revalidations, Reactivations, and Complete Form CMS-855 Applications

1. When Referral Required - In situations where the provider submits a (1) Form CMS-855 reactivation, (2) Form CMS-855 revalidation, or (3) full Form CMS-855 as part of a change of information (i.e., the provider has no enrollment record in PECOS), the contractor shall make a recommendation to the state and switch the PECOS record to "approval recommended" only if the application contains new/changed data falling within one of the categories in section 10.6.1.2(A)(1). For instance, if a revalidation application reveals a new hospital psychiatric unit that was never reported to CMS via the Form CMS-855, the contractor shall make a recommendation to the state and await the state's approval recommendation before switching the record to "Approved." In this situation, the contractor should forward the application to the state with a note explaining that the only matter the state needs to consider is the new hospital unit.

2. No Referral Required - If the application contains new/changed data falling within one of the categories in section 10.6.1.2(B), the contractor can switch the PECOS record to "Approved." It shall also inform the state of the changed information (via any mechanism it chooses, including copying the state on the notification letter or e-mail to the provider) no later than 10 calendar days after it has completed processing the transaction.

E. Unsolicited Notifications from State

If the contractor receives notice of a provider's change of information from the state but the provider never submitted the required Form CMS-855 change request to the contractor, the contractor shall: (1) alert the state of the situation; and (2) contact the provider and have it complete and submit the change request. However, if the data in question is not collected on the Form CMS-855, the contractor need not make this request.

F. Special ESRD Instructions

Notwithstanding any other contrary instruction in this chapter, if an ESRD change of information application results in the issuance of a new or additional CCN, the contractor shall copy the ESRD Network on the approval letter it sends to the provider. The contact information for the ESRD Network can be found at https://esrdnetworks.org/membership/esrd-networks-contact-information/.

G. Clock Stoppages and Processing Alternatives - While awaiting PEOG's reply on any matter in this section 10.6.1.2 in which the contractor is required to refer a matter to PEOG - and beginning on the date following the sending of the e-mail referenced therein - the application processing time clock is stopped. It resumes on the date on which the contractor receives PEOG's final response. Communication between the contractor and PEOG during this "waiting period" (e.g., PEOG request for additional information from the contractor) does not restart the clock.

In addition, nothing in this section 10.6.1.2 negates other permissible clock stoppages and processing alternatives outlined in this chapter that can apply to the applications addressed in this section 10.6.1.2.

10.6.21 – Miscellaneous Enrollment Topics

(Rev. 11859; Issued: 02-16-23; Effective: 03-17-23; Implementation: 03-17-23)

This section 10.6.21 addresses additional provider enrollment policies. Except as otherwise stated, the instructions in this section supersede any other instructions to the contrary in this chapter. It is anticipated that the provisions in this section 10.6.21 will eventually be moved to those sections of this chapter most applicable to their respective subject matter. For organizational reasons, section 10.6.21 is merely a placeholder section of chapter 10.

A. Group and Reassignment Reactivation

If a group practice submits a reactivation application after being deactivated for non-response to a revalidation request, the contractor shall reactivate the group's reassignments when the group's reactivation application has been approved; Form CMS-855I and/or CMS-855R applications for the reassignments are not required. The effective dates assigned to the reassigned providers shall align with the group's effective date per existing reactivation instructions.
This section 10.6.21(A) only applies to deactivations based on a non-response to a revalidation request.

B. Specialty Changes

When a Form CMS-855 enrollment application is submitted to report a change to a physician's or non-physician practitioner's primary or secondary specialty, the contractor shall not contact the physician, non-physician practitioner, or contact person directly to confirm either the change itself or the individual's intent to change his/her specialty.

C. Reassignments Related to Revoked or Deactivated Reassignee

The contractor shall end-date in PECOS all reassignment associations and the associated Provider Transaction Access Numbers (PTANs) when revoking or deactivating an individual or organization (reassignee) that is receiving reassigned benefits from an individual practitioner. The end-date shall be the same as the effective date of the revocation or deactivation; this will ensure the appropriate end-date in the Multi-Carrier System (MCS) and prevent improper use of those PTANs. However, the contractor shall not deactivate the individual practitioner's (reassignor's) enrollment record even if (1) the reassigned PTAN is the only PTAN on the individual's enrollment record and/or (2) no other active locations exist (private practice locations or reassignments); the contractor shall allow the practitioner's/reassignor's enrollment record to remain in an approved status.

When sending a deactivation, revocation, or voluntary withdrawal letter to the deactivated or revoked non-certified Part B supplier, said letter shall include the following language: "Please notify all physician assistants and/or group members who reassign benefits to your

organization that, in accordance with 42 CFR §424.540(a)(2), their Medicare enrollment status may be deactivated if they fail to update their enrollment record within 90 calendar days.

D. Interstate License Compacts

A new trend in medicine has arisen involving interstate license compacts. While physician compacts streamline the licensure process for physicians who want to practice in multiple states, a separate license from each state in which the physician intends to practice is still issued (if all requirements are met). CMS will continue to rely on the license issued by the state medical board to help confirm compliance with federal requirements.

In a similar vein, certain non-physician practitioner (NPP) compacts allow the NPP to work in a compact member state (other than their home state) without going through the normal process for licensure in the remote state. NPPs working under the authorization of such a compact must meet both the licensure requirements outlined in the primary state of residence and those established by the compact laws adopted by the legislatures of the interstate compact states.

At present, there are interstate compacts involving physicians, physical therapists, occupational therapists, speech language pathologists, and psychologists (though none for nurse practitioners). More are possible.

Licenses obtained through an interstate license compact for the above supplier types shall be treated as valid, full licenses for the purposes of meeting federal requirements. The contractor shall thus accept Form CMS-855 applications from applicants reporting a license obtained via an interstate license compact. In addition, the contractor shall attempt to verify the interstate license obtained through the compact using the state licensing board website(s) or compact website (if one exists); if neither technique can confirm the interstate license, the contractor shall request documentation from the supplier that validates said data.

E. Provisions in CMS-1770-F

The CMS Calendar Year 2023 Physician Fee Schedule Final Rule (CMS-1770-F) included a number of revisions to our provider enrollment regulations. This subsection 10.6.21(E) addresses these matters. Effective January 1, 2023, the contractor shall apply and execute the policies in this subsection 10.6.21(E) notwithstanding any other instruction to the contrary in this chapter.

1. Managing Organizations, Officers, and Directors

a. Definitions

CMS-1770-F finalized definitions of managing organization, officer, and director in 42 CFR § 424.502. These definitions are consistent with those commonly understood in the provider enrollment arena and are as follows:

- Managing organization - An entity that exercises operational or managerial control over, or who directly or indirectly conducts, the day-to-day operations of the provider or supplier, either under contract or through some other arrangement.
- Officer - An officer of a corporation, regardless of whether the provider or supplier is a non-profit entity.
- Director - A director of a corporation, regardless of whether the provider or supplier is a non-profit entity. This includes any member of the corporation's governing body

irrespective of the precise title of either the board or the member; said body could be a board of directors, board of trustees, or similar body.

Officers and directors can also include persons who serve in a voluntary or ceremonial capacity. CMS re-emphasizes, however, that officers and directors apply only to corporations.

Managing organizations, officers, and directors have long been reported in Section 5 or 6 (as applicable) of the Form CMS-855 and on the Form CMS-20134. The contractor shall continue to follow existing instructions in this chapter for: (1) ensuring that these parties and all required data pertaining thereto are disclosed, such as EINs/SSNs and any adverse legal history; and (2) performing all required verifications (e.g., reviewing against the OIG excluded parties list).

b. Expansion of § 424.530(a)(2)/(3) and § 424.535(a)(2)/(3)

Managing organizations, officers, and directors have been added to the scope of the denial/revocation reasons at §§ 424.530(a)(2), 424.530(a)(3), 424.535(a)(2), and 424.535(a)(3). This means that a felony conviction within the past 10 years, an OIG exclusion, or a SAM debarment against an officer, director, or managing organization can serve as the basis for the provider/supplier's denial/revocation. The contractor shall continue to follow existing instructions in this chapter for handling potential denial and revocation situations with the understanding that officers, directors, and managing organizations now fall within the aforementioned denial and revocation reasons. Thus, for example, if an officer of the provider has a current OIG exclusion, the contractor shall handle the matter in the same fashion it would if a supervising physician were excluded.

Note that CMS-1770-F also formally incorporated into § 424.530(a)(2)/(3) and § 424.535(a)(2)/(3) the policy that the individuals and entities listed within these regulatory provisions include W-2 employees and contracted individuals and organizations of the provider/supplier.

c. Expansion of § 424.530(c) and § 424.535(e)

As mentioned in sections 10.4.2.3(B) and 10.6.18(C)(7) of this chapter, §§ 424.530(c) and 424.535(e) state that if a denial or revocation, respectively, was due to a prior adverse action (such as a sanction, exclusion, or felony) against a provider/supplier's owner, managing employee, authorized or delegated official, medical director, supervising physician, or other health care or administrative or management services personnel furnishing services payable by a federal health care program, the denial or revocation may be reversed if the provider/supplier terminates (and submits proof that it has terminated) its business relationship with that party within 30 days of the denial/revocation notification. CMS-1770-F added officers, directors, and managing organizations to §§ 424.530(c) and 424.535(e).

2. Clarification of § 424.535(a)(12)

As stated in § 424.535(a)(12) and in section 10.4.7.3(L) of this chapter, CMS may revoke a provider or supplier that is terminated, revoked, or otherwise barred from participation in a state Medicaid program or any other federal health care program. Under § 424.535(a)(12)(ii), CMS cannot revoke unless and until the provider or supplier "has exhausted all applicable appeal rights." However, CMS-1770 added the following to the end of this quoted language in § 424.535(a)(12)(ii): "or the timeframe for filing an appeal has expired without the provider or supplier filing an appeal." This merely incorporated into regulation CMS' existing policy that § 424.535(a)(12) can be applied if the provider or supplier fails to file an appeal within the prescribed timeframe.

3. Expansion of Providers and Suppliers Undergoing High-Risk Screening

CMS-1770-F also expanded the number and types of providers and suppliers that are subject to high-risk level screening under § 424.518. This generally involves, but is not limited to: (1) moving skilled nursing facilities (SNFs) from the "limited" screening category to the "high" screening category; and (2) including certain changes in ownership as among the types of enrollment transactions subject to the "high" screening category under § 424.518. These regulatory changes and the associated contractor instructions for effectuating them are described in (a) through (c) below.

a. Changes in Ownership

i. General Policy

As stated in § 424.518 and as described in section 10.6.15 of this chapter, the following three application types are subject to § 424.518's screening requirements: (1) initial applications; (2) revalidations; and (3) applications to add a new practice location. CMS-1770-F added the following two transaction types to the purview of § 424.518:

(i) Change of ownership applications pursuant to 42 CFR § 489.18
(ii) Applications to report any new owner (regardless of ownership percentage, though consistent with the definition of owner in section 10.1.1 of this chapter) pursuant to a change of information or other enrollment transaction under title 42.

The foregoing means that an application under (i) or (ii) must be processed at the high screening level if it is submitted by:

- An enrolled OTP that has not been fully and continuously certified by SAMHSA since October 24, 2018
- A DMEPOS supplier
- An MDPP supplier
- An HHA
- A SNF (described further below)

(For purposes of this subsection (E)(3)(a), these five provider/supplier types will be collectively referred to as the "affected providers.")

Categories (i) and (ii) above would include, for instance:

- A SNF CMS-855A CHOW, acquisition, merger, and consolidation application (as those terms are described on the CMS-855A and in section 10.6.1.1 of this chapter).

- An HHA CHOW under 42 CFR § 489.18. (See section 10.2.1.6.1 of this chapter for information on these types of CHOWs.) Note that a change in majority ownership under 42 CFR § 424.550(b) that requires a new enrollment would not fall under (i) or (ii) above because it would generate an initial enrollment, though, for this latter reason, it would still be processed at the high screening level (as all HHA initials are).)

- A DMEPOS supplier reporting a 15 percent new owner.

In sum, any change of/in ownership that meets all the following criteria would fall under (i) and (ii) above:

- Does not involve the triggering of an initial enrollment (e.g., an HHA change in majority ownership and no exception applies, thus warranting a new enrollment); and
- The change reports either:

    - For partnerships: A new partner (general or limited) that owns any percentage (even 1 percent) of the affected provider; or
    - Excluding partnerships: A new direct or indirect owner of at least 5 percent of the affected provider.

Changes of ownership involving providers/suppliers other than the five aforementioned affected provider categories (e.g., ambulance suppliers, CORFs) shall continue to be processed consistent with existing instructions.

ii. Processing Instructions

Upon receipt of an application described in subsection (E)(3)(a)(i) above, the contractor shall process it consistent with the instructions in this chapter and, in particular, with section 10.6.15. This includes requesting fingerprints from any new direct or indirect owner of 5 percent or more of the provider, though the contractor need not also solicit them from the provider/supplier's existing owners; only the new owner(s) need be fingerprinted.

The contractor shall also order a site visit of the affected provider consistent with existing instructions. In terms of the timing of the HHA or SNF site visit, however, the contractor shall also adhere to the following:

- No State/SOG Location Approval Required – If the ownership change does not require state or SOG Location approval under existing CMS instructions (see sections 10.6.1.1, 10.6.1.2, 10.6.22, and 10.6.22.1 of this chapter for more information), the site visit shall be ordered and performed prior to the contractor's final decision regarding the application.
- State/SOG Location Approval Required - If the ownership change requires state or SOG Location approval under existing CMS instructions (see sections 10.6.1.1, 10.6.1.2, 10.6.22, and 10.6.22.1), the site visit shall be ordered and performed no later than 5 business days after the contractor receives notice of approval from the state or SOG Location but before the contractor switches the provider/supplier's enrollment record to an "Approved" status.

All clock stoppages permitted under this chapter (e.g., fingerprinting per section 10.5(C)(1)) apply to the situations described in this subsection (E)(3)(a). In addition, since a site visit and fingerprinting are required, the contractor shall adhere to the timeliness standards in section 10.5(A)(1)(a) for paper applications and those in section 10.5(A)(3)(a) for web-based applications.

b. SNFs

As already mentioned, SNFs are now in the "high" screening category under § 424.518(c). Accordingly, SNF initial applications require a site visit as well as the fingerprinting of the SNF's 5 percent or greater owners. In executing this policy, the contractor shall follow existing instructions in this chapter regarding the collection and processing of fingerprints, including those in subsection (E)(3)(a) above for SNF ownership changes. As for site visits, the contractor shall follow the instructions in section 10.2.1.14 for initial and revalidation applications and subsection (E)(3)(a) above for change in ownership applications.

c. "Bump-Ups"

Effective January 1, 2023 (and pursuant to CMS-1770-F), any screening level adjustment under § 424.518(c)(3) also applies to all other enrolled and prospective providers and suppliers that have the same legal business name and tax identification number as the provider or supplier for which the screening level under § 424.518(c)(3) of this section was originally raised. See section 10.6.15(A)(4) of this chapter for more information.

F. Special Form CMS-855S Instructions

1. Addresses

If an address (e.g., correspondence address, practice location) on the Form CMS-855S lacks a city, state, or zip + four, the contractor can verify the missing data in any manner it chooses. In addition, the contractor can obtain the zip + four from either the U.S. Postal Service or the Delivery Point Validation in PECOS.

2. Insurance

With respect to the comprehensive liability insurance supplier standard in 42 CFR § 424.57(a)(10), the contractor shall: (1) verify with the insurance agent that the insurance policy is active and current; and (2) ensure that the contractor (i.e., the NPE contractor) is listed as the policy holder on the certificate. The contractor may contact the insurance agent via any manner it chooses; however, verification shall be documented consistent with section 10.6.19 of this chapter (e.g., documenting telephonic communications).

G. Transitioned Certified Providers and Suppliers – E-Mails to PEOG for Final Application Review and/or Approval

As described in this chapter, the contractor must refer various matters involving transitioned certified provider/supplier enrollment applications to PEOG for final application review and approval (e.g., system updates, assignment of CCN, etc.) When making such referrals---and notwithstanding any other instruction to the contrary in this chapter---the e-mail subject line shall include the following: SUBJECT LINE: S&C: Facility Type; Application Type; Facility Name; National Provider Identifier; CCN; Application Receipt Date (MMDDYY) (*Date the Contractor Received the Application from the Provider/Supplier). (Note, however, that this data need not be duplicated in the e-mail's body.) This instruction, to reiterate, only applies to e-mails to PEOG involving: (1) transitioned certified providers/suppliers; and (2) instances where the contractor is explicitly required per this chapter to send the matter PEOG for final review, approval, and/or denial of an application (e.g., initial application, CHOW, certain COIs) and to wait for PEOG's determination. (See, for example, section 10.6.1.2(A)(3)(a) of this chapter.)*

H. Contacting State or SOG Location for Updates

1. "Transitioned" Certified Providers/Suppliers - In situations where the contractor recommends approval to the state (initial applications, CHOWs, certain changes of information, etc.), the contractor---if it has not received the state's recommendation within 120 days after the contractor sent its recommendation---may contact the state to ascertain whether said recommendation is forthcoming. The contractor may contact the state every 30 days thereafter to determine the recommendation's status.

2. "Non-Transitioned" Certified Providers/Suppliers – If, as described in subsection (H)(1) above, the contractor recommends approval to the state, the contractor may contact the state for an update on the recommendation's status beginning 120 days after the recommendation was sent and every 30 days thereafter. If the state informs the contractor (via any means) that the application has been forwarded to the SOG Location, the contractor may contact the

SOG Location for a status update every 30 days beginning on the date the contractor received this notice from the state.

10.6.22 - Non-Transitioned Certified Provider/Supplier Changes of Ownership

(Rev. 11859; Issued: 02-16-23; Effective: 03-17-23; Implementation: 03-17-23)

(Until further notice, the contractor shall continue to follow these instructions for CHOWs involving those certified provider and certified supplier types that have not "transitioned" as described in section 10.6.1.1 of this chapter.)

All references to the SOG Location (formerly the "RO") in this section 10.6.22 refer to the applicable CMS Regional Office's Survey & Operations Group (SOG) Location. Also, and except as otherwise indicated, all references to "provider" include certified suppliers (e.g., ambulatory surgical centers, portable x-ray suppliers).

Changes of ownership (CHOWs) are officially defined in and governed by 42 CFR § 489.18 and Publication 100-07, chapter 3, sections 3210 through 3210.5(C). The SOG Location – not the contractor – makes the determination as to whether a CHOW has occurred (unless this function has been delegated).

Except as otherwise specified, the term "CHOW" - as used in this section 10.6.22 - includes CHOWs, acquisitions/mergers, and consolidations.

Though the Change of Ownership (CHOW) Information section of the Form CMS-855A separates the applicable transactions into CHOWs, acquisition/mergers and consolidations for ease of disclosing and reporting, they fall within the general CHOW category under 42 CFR § 489.18 (e.g., an acquisition/merger is a type of CHOW under § 489.18).

A. Definitions for CHOWs

For purposes of provider enrollment only, there are three main categories of CHOWs captured on the Form CMS-855A application:

1. "Standard" CHOW

This occurs when a provider's CMS Certification Number (CCN) and provider agreement are transferred to another entity as a result of the latter's purchase of the provider. To illustrate, suppose Entity A is enrolled in Medicare, but Entity B is not. B acquires A. Assuming all regulatory requirements are met, A's provider agreement and CCN number will transfer to B.

This is the most frequently encountered change of ownership scenario. As explained in this section 10.6.22, even though it is technically an acquisition (i.e., B bought/acquired A) under § 489.18, this situation falls under the "CHOW" category – as opposed to the "Acquisition/Merger" category – on the Form CMS-855A.

2. Acquisition/Merger

In general, this occurs when two or more Medicare-enrolled entities combine, leaving only one remaining CCN number and provider agreement. For instance, Entity A and Entity B are both enrolled in Medicare, each with its own CCN number and provider agreement. The two entities decide to merge. Entity B's CCN number and provider agreement will be eliminated (leaving only Entity A's CCN number and provider agreement).

If the acquisition results in an existing provider having new owners but keeping its existing provider number, the applicant should check the CHOW box in the Basic Information section of the Form CMS-855A.

Unlike the new owner in a CHOW or consolidation, the new owner in an acquisition/merger need not complete the entire Form CMS-855A. This is because the new owner is already enrolled in Medicare. As such, the provider being acquired should be reported as a practice location in the Practice Location Information section of the new owner's Form CMS-855A.

3. Consolidations

This occurs when the merger of two or more Medicare-enrolled entities results in the creation of a brand new entity. To illustrate, if Entities A and B decide to combine and, in the process, create a new entity (Entity C), the CCN numbers and provider agreements of both A and B will be eliminated. Entity C will have its own CCN number and provider agreement.

Note the difference between acquisitions/mergers and consolidations. In an acquisition/merger, when A and B combine there is one surviving entity. In a consolidation, when A and B combine there are no surviving entities. Rather, a new entity is created – Entity C.

Under 42 CFR § 489.18(a)(4), the lease of all or part of a provider facility constitutes a change of ownership of the leased portion. If only part of the provider is leased, the original provider agreement remains in effect only with respect to the un-leased portion. (See Pub. 100-07, chapter 3, section 3210.1D (4) for more information.)

Note that a provider may undergo a financial or administrative change that it considers to be a CHOW, but does not meet the regulatory definition identified in §489.18.

B. Examining Whether a CHOW May Have Occurred

As stressed previously, the SOG Location – not the contractor – determines whether a CHOW has occurred (unless this function has been delegated). However, in processing the application, the contractor shall perform all necessary background research regarding whether: (1) a CHOW may have occurred, and/or (2) the new owner is accepting assignment of the Medicare assets and liabilities of the old owner. Such research may include reviewing the sales agreement or lease agreement, contacting the provider(s) to request clarification of the sales agreement, etc. (A CHOW determination by the SOG Location is usually not required prior to the contractor making its recommendation.)

While a CHOW is usually accompanied by a tax identification number (TIN) change, this is not always the case. There may be isolated instances where the TIN remains the same. Conversely, there may be cases where a provider is changing its TIN but not its ownership. In short, while a change of TIN (or lack thereof) is evidence that a CHOW may or may not have occurred, it is not the most important factor; rather, the change in the provider's ownership arrangement is. Hence, the contractor should review the sales/lease agreement closely, as this will help indicate whether a CHOW may or may not have occurred.

In addition:

(a) If the provider claims that the transaction in question is a stock transfer and not a CHOW, the contractor reserves the right to request any information from the provider to verify this (e.g., copy of the stock transfer agreement).

If – after performing the necessary research – the contractor remains unsure as to whether a CHOW has occurred and/or whether the new owner is accepting assignment, the contractor may refer the matter to the SOG Location for guidance. Such referrals to the SOG Location should only be made if the contractor is truly uncertain as to whether a CHOW and/or acceptance of assignment may have taken place and should not be made as a matter of course. A SOG Location CHOW determination is usually not required prior to the contractor making its recommendation.

(b) There may be instances where the contractor enters a particular transaction into PECOS as a CHOW, but it turns out that the transaction was not a CHOW (e.g., was a stock transfer; was an initial enrollment because the new owner refused to accept the Medicare liabilities). If the contractor cannot change the transaction type in PECOS, it can leave the record in a CHOW status; however, it should note in the provider's file that the transaction was not a CHOW.

C. Processing CHOW Applications

Unless stated otherwise in this chapter, the contractor shall ensure that all applicable sections of the Form CMS-855A for both the old and new owners are completed in accordance with the instructions on the Form CMS-855A.

1. Previous Owner(s)

The previous owner's Form CMS-855A CHOW application does not require a recommendation for approval. Any recommendations will be based on the CHOW application received from the new owner.

If the previous owner's Form CMS-855A is available at the time of review, the contractor shall examine the information therein against the new owner's Form CMS-855A to ensure consistency (e.g., same names). If the previous owner's Form CMS-855A has not been received, the contractor shall contact the previous owner and request it. However, the contractor may begin processing the new owner's application without waiting for the arrival of the previous owner's application. It may also make its recommendation to the state agency without having received the previous owner's Form CMS-855A. The contractor, of course, shall not make a recommendation for approval unless the new owner has checked on the form that it will assume the provider agreement and the terms of the sales agreement indicate as such.

If a certification statement is not on file for the previous owner, the contractor shall request that the Individual Ownership and/or Managing Control section be completed for the individual who is signing the certification statement.

Note that a previous owner's Form CMS-855A CHOW application is essentially the equivalent of a Form CMS-855 voluntary termination submission, as the seller is voluntarily leaving the Medicare program. As such, the contractor shall not require the seller to submit a separate Form CMS-855 voluntary termination along with its Form CMS-855A CHOW application.

2. New Owner(s)

If a Form CMS-855A is not received from the new owner within 14 calendar days of receipt of the previous owner's Form CMS-855A, the contractor shall contact the new owner. *If, within 30 calendar days after the contractor contacted it, the new owner fails to (1) submit a Form CMS-855A and (2) indicate that it accepts assignment of the provider agreement, the contractor shall send an e-mail to its PEOG BFL notifying him/her of the situation. PEOG*

will determine whether the provider's billing privileges should be deactivated under § 424.540(a)(2) or § 424.550(b) or revoked under § 424.535(a)(1) or (a)(9). PEOG will notify the contractor of its decision.

3. Order of Processing

To the maximum extent practicable, Form CMS-855A applications from the previous and new owners in a CHOW should be processed as they come in. The contractor should not wait for applications from both the previous and new owner to arrive before processing them. However, unless the instructions in this chapter indicate otherwise, the contractor should attempt to send the previous and new owners' applications to the state simultaneously, rather than as soon as they are processed. For instance, suppose the previous owner submits an application on March 1. The contractor should begin processing the application immediately, without waiting for the arrival of the new owner's application. Yet it should avoid sending the previous owner's application to the state until the new owner's application is processed. (For acquisition/mergers and consolidations, the contractor may send the applications to the SOG Location separately, since one number is going away.)

4. Sales and Lease Agreements

The contractor shall abide by the following:

(i) Verification of Terms - The contractor shall determine whether: (1) the sales/lease agreement includes the signatures of the buyer and seller and the information contained within is consistent with that reported on the new owner's Form CMS-855A (e.g., same names, effective date), and (2) the terms of the contract indicate that the new owner will assume the provider agreement. In many cases, the sales/lease agreement will not specifically refer to the Medicare provider agreement. Clearly, if the box in the Change of Ownership (CHOW) Information section is checked "Yes" and the sales/lease agreement either confirms that the new owner will assume the agreement or is relatively silent on the matter, the contractor can proceed as normal. Conversely, if the agreement indicates that the assets and liabilities will not be accepted, the contractor should deny the application.

(Note that--

- *A bill of sale/lease agreement/sales transfer agreement is a sales/lease business document and should not be confused with a patient transfer agreement.*
- *The agreement must contain the signatures of both parties to the transaction. If it does not, the contractor shall develop for an agreement containing both signatures.)*

(ii) Form of Sales/Lease Agreement - There may be instances where the parties in a CHOW did not sign a "sales" or "lease" agreement in the conventional sense of the term; the parties, for example, may have documented their agreement via a "bill of sale." The contractor may accept this documentation in lieu of a sales/lease agreement so long as the document furnishes clear verification of the terms of the transaction and the information is consistent with that contained in the Form CMS-855A as discussed above.

(iii) Submission of Final Sales/Lease Agreement - The contractor shall not forward a copy of the application to the state until it has received and reviewed the final sales/lease agreement. It need not revalidate the information on the Form CMS-855A, even if the data therein may be somewhat outdated by the time the final agreement is received.

If a final sales/lease agreement is not submitted within 30 days after the contractor's receipt of the new owner's application, the contractor shall reject the application. Though the contractor must wait until the 30th day to reject the application, the contractor may do so

regardless of how many times it contacted the new owner or what types of responses (short of the actual receipt of the agreement) were obtained.

Unless specified otherwise in this chapter, both the previous and new owners must submit separate Form CMS-855A applications, as well as copies of the interim and final sales/lease agreements.

5. CHOWs Involving Subtypes

On occasion, a CHOW may occur in conjunction with a change in the facility's provider subtype. This frequently happens when a hospital undergoes a CHOW and changes from a general hospital to another type of hospital, such as a psychiatric hospital. Although a change in hospital type is considered a change of information (COI), it is not necessary for the provider to submit separate applications – one for the COI and one for the CHOW. Instead, all information (including the change in hospital type) should be reported on the CHOW application; the entire application should then be processed as a CHOW. However, if the facility is changing from one main provider type to another (e.g., hospital converting to a skilled nursing facility) and also undergoing a CHOW, the provider must submit its application as an initial enrollment.

NOTE: For Medicare purposes, a critical access hospital (CAH) is a separately-recognized provider type. Thus, a general hospital that undergoes a CHOW while converting to a CAH must submit its Form CMS-855A as an initial enrollment, not as a CHOW.

6. Unreported CHOW

If the contractor learns via any means (including receipt of a tie-in notice or other SOG Location or state notice) that an enrolled provider (1) has been purchased by another entity or has purchased another Medicare enrolled provider, the contractor shall immediately request Form CMS-855A applications from both the previous and new owners. If the new owner fails to submit a Form CMS-855A within the latter of (1) the date of acquisition or (2) 30 days after the request, the contractor shall stop payments to the provider. Payments may be resumed upon receipt of the completed Form CMS-855A.

7. Relocation of Entity

A new owner may propose to relocate the provider concurrent with the CHOW. If the relocation is to a site in a different geographic area serving different clients than previously served and employing different personnel to serve those clients, the contractor shall notify the SOG Location immediately. Unless the SOG Location dictates otherwise, the provider shall - per CMS Publication 100-07, chapter 3, section 3210.1(B)(5) - treat the transaction as an initial enrollment (and the provider as a new applicant), rather than as an address change of the existing provider.

8. Transitioning to Provider-Based Status

Consistent with existing CMS policy, a provider undergoing a CHOW pursuant to 42 CFR § 489.18 may be assigned to a new contractor jurisdiction only if the provider is transitioning from freestanding to provider-based status. In such cases, the contractor for the new jurisdiction (the "new contractor") shall process both the buyer's and seller's Form CMS-855A applications. Should the "old/previous" (or current) contractor receive the buyer's and/or seller's Form CMS-855A application, it shall: (a) forward the application to the new contractor within 5 business days of receipt, and (b) notify the new contractor within that same timeframe that the application was sent.

9. Intervening Change of Ownership (CHOW)

(This section does not apply to home health agencies.)

In situations where (1) the provider submits a Form CMS-855A initial application or CHOW application and (2) a Form CMS-855A CHOW application is subsequently submitted but before the contractor has received the tie-in notice from the SOG Location, the contractor shall abide by the following:

Situation 1 – The provider submitted an initial application followed by a CHOW application, and a recommendation for approval has not yet been made with respect to the initial application – The contractor shall return both applications and require the provider to re-submit an initial application with the new owner's information.

Situation 2 - The provider submitted a CHOW application followed by another CHOW application, and a recommendation for approval has not been made for the first application - The contractor shall process both applications – preferably in the order in which they were received – and shall, if recommendations for approval are warranted, refer both applications to the state/SOG Location in the same package. The accompanying notice/letter to the state/SOG Location shall explain the situation.

Situation 3 - The provider submitted an initial application followed by a CHOW application, and a recommendation for approval of the initial application has been made – The contractor shall:

(i) Return the CHOW application.

(ii) Notify the state/SOG Location via letter (sent via mail or e-mail) that there has been a change of ownership (the new owner should be identified) and that the contractor will be requiring the provider to resubmit a new initial application containing the new owner's information.

(iii) Request via letter that the provider submit a new initial Form CMS-855A application containing the new owner's information within 30 days of the date of the letter. If the provider fails to do so, the contractor shall return the initial application and notify the provider and the state/SOG Location of this via letter. If the provider submits the application, the contractor shall process it as normal and, if a recommendation for approval is made, send the revised application package to the state/SOG Location with an explanation of the situation; the initially submitted application becomes moot. If the newly submitted application is denied, however, the initially submitted application is denied as well; the contractor shall notify the provider and the state/SOG Location accordingly.

Situation 4 - The provider submitted a CHOW application followed by another CHOW application, and a recommendation for approval has been made for the first application - The contractor shall:

(i) Notify the state/SOG Location via e-mailed letter that there has been a change of ownership (the new owner should be identified) and that the contractor will be requiring the provider to resubmit a new initial application containing the new owner's information.

(ii) Process the new CHOW application as normal. If a recommendation for approval is made, the contractor shall send the revised CHOW package to the state/SOG Location with an explanation of the situation; the first CHOW application becomes moot. If the newly submitted CHOW application is denied, the first application is denied as well; the contractor shall notify the provider and the state/SOG Location accordingly.

10. CHOWs and Address Changes

A new owner may propose to relocate the supplier concurrent with a CHOW. If the relocation is to a site in a different geographic area serving different clients than previously served and employing different personnel to serve those clients, the contractor shall notify the SOG Location immediately. Unless the SOG Location dictates otherwise, the supplier shall - per Pub. 100-07, chapter 3, section 3210.1(B)(5) - treat the transaction as an initial enrollment (and the supplier as a new applicant), rather than as an address change of the existing supplier.

D. Form CMS-855A - Entry into PECOS

If the new owner will or will not be accepting assignment as well as the assets and liabilities of the old owner, the contractor shall enter the CHOW information into the new enrollment record that shall be created for the CHOW buyer. If the SOG Location approves the CHOW and sends the tie-in/approval notice to the contractor, the supplier's CCN will be maintained in the new owner's enrollment record once the record is switched to an approved status.

If the CHOW is for a Part B certified supplier, a new enrollment record must be created if a new TIN is created in the CHOW.

E. Form CMS-855A - Electronic Funds Transfer (EFT) Payments and CHOWs

In a CHOW, the contractor shall continue to pay the old owner until it receives the tie-in/approval notice from the SOG Location. Hence, any application from the old or new owner to change the EFT account or special payment address to that of the new owner shall be rejected. It is the responsibility of the old and new owners to work out any payment arrangements between themselves while the contractor and SOG Location are processing the CHOW. It is advisable that the contractor notify the new owner of this while the application is being processed.

In a CHOW, the existing provider agreement is automatically assigned to the buyer/transferee. If the buyer/transferee does not explicitly reject automatic assignment before the transfer date, the provider agreement is automatically assigned, along with the CCN, effective on the transfer date. The assigned agreement is subject to all applicable statutes and regulations and to the terms and conditions under which it was originally issued. Among other things, this means that the contractor will continue to adjust payments to the provider to account for prior overpayments and underpayments, even if they relate to services provided before the sale/transfer. If the buyer rejects assignment of the provider agreement, the buyer must file an initial application to participate in the Medicare program. In this situation, Medicare will **never** pay the applicant for services the prospective provides before the date on which the provider qualifies for Medicare participation as an initial applicant.

Depending on the terms of the sale, the buyer/transferee may obtain a new NPI or maintain the existing NPI. After CHOW processing is complete, the seller/transferor will no longer be allowed to bill for services (i.e., services furnished after CHOW processing is complete) and only the buyer is permitted to submit claims using the existing CCN. It is ultimately the responsibility of the old and new owners to work out between themselves any payment arrangements for claims for services furnished during the CHOW processing period.

F. Form CMS-855A CHOW: Pre-Approval Changes of Information

1. CHOW: Regarding Seller

If – prior to the issuance of the tie-in notice – the contractor receives from the seller a Form CMS-855 request to change any of the provider's enrollment data, the contractor shall reject the change request if the information in question involves changing the provider's:

i. EFT or special payment address information to that of the buyer

ii. Practice location or base of operations to that of the buyer

iii. Ownership or managing control to that of the buyer

iv. Legal business name, TIN, or "doing business as" name to that of the buyer

All other "pre-tie-in notice" Form CMS-855 change requests from the seller can be processed normally.

2. CHOW: Regarding Buyer

If – prior to the issuance of the tie-in notice – the contractor receives from the buyer a Form CMS-855 request to change any of the provider's existing enrollment information, the contractor shall reject the change request. Until the tie-in notice is issued, the seller remains the owner of record. Hence, the buyer has no standing to submit Form CMS-855 changes on behalf of the provider.

10.6.22.1 - Non-Transitioned Certified Provider/Supplier Changes of Information

(Rev. 11859; Issued: 02-16-23; Effective: 03-17-23; Implementation: 03-17-23)

(Until further notice, the contractor shall continue to follow these instructions for changes of information involving all certified provider and certified supplier types that have not "transitioned.")

All references to the SOG Location (formerly the "RO") in this section 10.6.22.1 refer to the applicable CMS Regional Office's Survey & Operations Group (SOG) Location. Also, and except as otherwise indicated, all references to "provider" include certified suppliers (e.g., ambulatory surgical centers, portable x-ray suppliers).

Any instructions in this section 10.6.22.1 concerning the voluntary termination of a sub-unit, or other practice location that does not involve the termination of the entire enrollment and/or provider agreement take precedence over those in section 10.6.1.3. For instance, suppose a certified provider's Form CMS-855A enrollment has three practice locations and/or sub-units. The provider is voluntarily terminating one of them. Here, the contractor shall use the instructions in section 10.6.22.1 (or, for transitioned providers/suppliers, section 10.6.1.2) when processing this transaction. Now assume that a provider is of a type that must individually and separately enroll each location. The provider has three separately enrolled locations with three separate provider agreements. The provider seeks to terminate one of these locations. Since this will involve the termination of an individual/entire enrollment and corresponding provider agreement, the instructions in section 10.6.1.3 apply.

A. Form CMS-855A - Referrals to State/SOG Location

1. Transactions

The following is a list of Form CMS-855A transactions that generally require a recommendation and referral to the state/SOG Location:

- Addition of hospice satellite

- Change in type of Prospective Payment System (PPS)-exempt unit

- Conversion of a hospital from one type to another (e.g., acute care to psychiatric)

- Addition of hospital physician/practitioner group practice location when a survey of the new site may be required. (If the contractor is uncertain as to whether the state will perform a survey, it may (1) contact the state for guidance or (2) make the referral based on the contractor's experience with these types of changes and with the practices of the state in question. Note that a survey often may be required if the location is shifting outside of the existing geographic area.)

- Excluding hospital physician/practitioner group practice locations, change and/or relocation of a practice location regardless of whether a survey of the new site may be required.

- *RHC change of address*

- Stock transfer (except as stated below in subsection (A)(2) below)

In these situations, the Provider Enrollment, Chain and Ownership System (PECOS) record should not be switched to "approved" until the contractor receives notice from the SOG Location that the latter has authorized the transaction. However, if the contractor knows that the particular state/SOG Location in question typically does not review, approve, or deny this type of transaction, the contractor need not send the transaction to the state/SOG Location for approval and shall instead follow the instructions in section 10.6.22.1(B) below.

2. Stock Transfers

If the transaction is a stock transfer, the contractor need not send the transaction to the state/SOG Location for approval (and shall instead follow the instructions in section 10.6.22.1(B) below) if the following three conditions are met:

(i) The contractor is confident that the transaction is merely a transfer of stock and not a CHOW,

(ii) The SOG Location in question (based on the contractor's past experience with this SOG Location) does not treat stock transfers as potential CHOWs, and

(iii) The contractor knows that the particular state/SOG Location in question does not review, approve, or deny this type of transaction.

If any of these three conditions are not met, the contractor shall send the transaction to the state/SOG Location for approval.

3. Additional Instructions

SOG Location approval for the transactions listed above in section 10.6.22.1(A)(1) may be furnished to the contractor via tie-in notice, letter, e-mail, fax, or even telephone; the contractor may accept any of these formats.

If the SOG Location (after receiving the transaction from the contractor for review) notifies the contractor that it does not normally review/approve/deny such transactions, the contractor may finalize the transaction (e.g., switch the PECOS record to "approved).

B. Form CMS-855A - Post-Approval SOG Location Contact Required

Form CMS-855A changes that do not mandate a recommendation to the state/SOG Location but do require post-approval correspondence with the SOG Location include:

- Deletions/voluntary terminations of practice locations or hospital subunits

- Legal business name, tax identification number, or "doing business as name" changes that do not involve a CHOW

- Except as described in section 10.6.22.1(A)(1), address changes that do not require a survey of the new location

- The transactions (excluding stock transfers) described in section 10.6.22.1(A)(1) for which the contractor knows that the state/SOG Location does not issue approvals/denials

- Stock transfers for which all three conditions mentioned in section 10.6.22.1(A)(2) are met

- Voluntary terminations of PTANs (except as otherwise stated in this section 10.6.22.1 and in section 10.6.1.3 of this chapter)

For these transactions, the contractor shall: (1) notify the provider via letter, fax, e-mail, or telephone that the change has been made, and (2) switch the PECOS record to "approved." The contractor shall also notify the state and SOG Location of the changed information (via any mechanism it chooses, including copying the state/SOG Location on the notification letter or e-mail) no later than 10 calendar days after it has completed processing the transaction. Such notice to the State/SOG Location shall specify the type of information that is changing.

C. Form CMS-855A - All Other Changes of Information

For all Form CMS-855A change requests not identified in section 10.6.22.1(A) or (B), the contractor shall notify the provider via letter, fax, e-mail, or telephone that the change has been made and shall switch the PECOS record to "approved." The state and SOG Location need not be notified of the change.

D. Form CMS-855A Revalidations, Form CMS-855A Reactivations and Complete Form CMS-855A Applications

In situations where the provider submits a: (1) Form CMS-855A reactivation, (2) Form CMS-855A revalidation, or (3) full Form CMS-855A as part of a change of information (i.e., the provider has no enrollment record in PECOS), the contractor shall make a recommendation to the state/SOG Location and switch the PECOS record to "approval recommended" only if the application contains new/changed data falling within one of the categories in 10.6.22.1(A)(1). For instance, if a revalidation application reveals a new hospital psychiatric unit that was never reported to CMS via the Form CMS-855A, the contractor shall make a recommendation to the state/SOG Location and await the SOG Location's approval before switching the record to "approved." In this situation, the contractor should forward the application to the state with a note explaining that the only matter the state/SOG Location needs to consider is the new hospital unit.

If the application contains new/changed data falling within one of the categories in section 10.6.22.1(B), the contractor can switch the PECOS record to "approved." It shall also notify

the state and SOG Location of the changed information (via any mechanism it chooses, including copying the state/SOG Location on the notification letter or e-mail) no later than 10 calendar days after it has completed processing the transaction.

10.6.23 – Special Instructions for Electronic Funds Transfer (EFT) Accounts and Special Payment Addresses

(Rev. 11859; Issued: 02-16-23; Effective: 03-17-23; Implementation: 03-17-23)

(The instructions in this section 10.6.23 take precedence over all other contrary instructions in this chapter, including, but not limited to, the existing guidance in sections *10.3,* 10.3.1.1.4, 10.3.1.2.4, and 10.3.1.3.4. The policies in this section will eventually be incorporated into the sections of this chapter that are applicable to the subject matter.)

A. Enrolled Providers/Suppliers

1. General Policy

A provider/supplier may only have one EFT account and one special payment address (SPA) per enrollment. As a general rule, multiple EFT accounts or SPAs within an existing enrollment will remain in effect only until the provider/supplier submits any update to its EFT information or SPA data, respectively, for any of these accounts or addresses. At that time, the EFT account or SPA for which the provider/supplier submitted the update will become the lone EFT account or SPA (as applicable) for that enrollment.

For purposes of this requirement:

(i) The term "enrollment" means a single enrollment in a single state involving a single provider/supplier type. The particular PTAN arrangement under the enrollment (e.g., a group practice has three practice locations under its Form CMS-855B enrollment, each with a separate PTAN) is irrelevant for purposes of this requirement; again, the requirement is based on the enrollment, not the PTAN.

(ii) Any submitted change to any of the provider/supplier's EFT or SPA data for any EFT account or SPA within an enrollment --- even a change that the provider/supplier did not cause (e.g., a government-generated zip code change) and even if it is for only one of the enrollment's EFT accounts or SPAs --- triggers the aforementioned requirement. The materiality of the change does not matter. However, the changed data must have actually been submitted via the appropriate CMS form to invoke the requirement; using the example in the previous sentence, this zip code change would not trigger the requirement unless and until the provider/supplier reports it via a CMS form.

(iii) If the provider/supplier reports the changed EFT or SPA data as part of a revalidation, reactivation, or other enrollment transaction other than a change of information (COI), the requirement is invoked to the same extent as with a COI.

(iv) The requirement applies only to the precise enrollment (e.g., "Enrollment A") for which the change was submitted. It is inapplicable to the provider/supplier's other enrollments ("Enrollments B and C"), even if B and C have:

- Multiple EFT accounts or SPAs that match those for which the provider/supplier reported a change to its "Enrollment A" EFT or SPA data; and/or
- The same LBN or TIN as "Enrollment A."

(v) A change in EFT data does not invoke the need to "consolidate" the provider/supplier's SPAs if the provider/supplier has multiple SPAs; likewise, a change in SPA data does not

require the "consolidation" of the provider/supplier's multiple EFT accounts. (For purposes of this section 10.6.23, the term "consolidate" simply means reducing the provider/supplier's multiple EFT accounts or SPAs to one.)

(vi) Even if the multiple EFT accounts are with the same banking institution, the aforementioned "consolidation" requirement applies.

(vii) Any EFT and/or SPA consolidation under this section 10.6.23 applies to all PTANs under the single enrollment.

(viii) The consolidation requirement *only* applies *if* the EFT or SPA change that the provider/supplier submitted is approved. *It is inapplicable if the change is denied, rejected, or returned.*

(ix) The term "multiple" EFT accounts or SPAs only applies to active EFT accounts/SPAs.

(x) Except as otherwise noted, any consolidation described in this section 10.6.23 becomes effective on the date of the applicable approval letter (see subsection (A)(2)(i) below).

Consider the following:

> EXAMPLE – Provider X is enrolled as a group practice and a HIT supplier (i.e., two separate enrollments) in State Y. Currently:
>
> - The group practice enrollment has two EFT accounts (one with Smith Bank and one with Jones Bank) and two SPAs (1 James Street and 200 Johnson Street)
> - The HIT supplier enrollment has the same two EFT accounts and SPAs as the group practice
>
> Provider X submits a change to its Smith Bank account information for the group practice enrollment. *The change is approved.* In this scenario: (1) the Smith Bank account becomes the lone EFT account for the group practice; (2) the group practice's Jones Bank account becomes inactive in PECOS effective on the date of the notice to the provider/supplier that the originally submitted EFT or SPA change was approved, denied, etc. (see subsection (A)(2)(i) below); (3) the Smith Bank and Jones Bank accounts for the HIT supplier enrollment are unaffected; and (4) the SPAs for Provider X's two enrollments are unaffected.

2. Operational Procedures

If the contractor receives an EFT or SPA change and determines that the provider/supplier has multiple EFT accounts or SPAs (as applicable and consistent with the guidelines described in subsection (A) above) for that enrollment, the contractor shall follow the procedures described below. (The example in subsection (A) will be used as a format.)

Step 1 – The contractor shall process the EFT data change for the group practice's Smith Bank account as normal.

Step 2 – Upon final completion of its processing of the change and *assuming the change is approved*, the contractor shall:

i. Send the appropriate approval letter to the provider/supplier consistent with the instructions in this chapter. The contractor shall, however, add the following language to the letter:

"Under CMS policy, a Medicare provider or supplier may only have one ["EFT account" or "special payment address", as applicable] per enrollment. Consistent therewith, [Contractor name] has designated the ["EFT account" or "special payment address", as applicable] for which you reported changed ["EFT" or "special payment address"] information as the sole ["EFT account" or "special payment address"] for this enrollment. This designation is effective as of the date of this letter. All payments previously sent to your other ["EFT account(s)" or "special payment address(es)"] under this enrollment will now be made to the sole designated ["EFT account" or "special payment address"] described above. If you wish to change this sole designated ["EFT account or "special payment address"], you must submit the applicable [Form CMS-588, Form CMS-855, or Form CMS-20134, as applicable] to do so.

Note that the sole designation described above applies only to the enrollment for which you submitted the requested change to your ["EFT" or "special payment address'] data. It is inapplicable to any other enrollments you have."

The contractor may: (1) notwithstanding any other instruction to the contrary in section 10.7 et seq. of this chapter, alter the forgoing language to conform to the provider/supplier's particular factual situation (prior CMS approval is unnecessary); and (2) insert said language in any part of the letter it chooses.

ii. End-date the "other" EFT account(s) or SPA(s) (as applicable) effective the date of the letter described in subsection (A)(2)(i) above. The contractor shall make all payments under the enrollment to the sole account/SPA beginning the day after the date of the letter.

iii. Apply the PTAN(s) associated with the deleted EFT account/SPA to the sole EFT account/SPA.

iv. Complete all other normal steps required under this chapter for finalizing the transaction in question.

B. Providers/Suppliers Initially Enrolling or Undergoing a CHOW Consistent with Principles of 42 CFR § 489.18

The aforementioned policy that a provider/supplier may only have one EFT account and one SPA per enrollment also applies to: (1) providers/suppliers submitting an initial enrollment application; and (2) new owners in a certified provider/supplier CHOW (i.e., a CHOW consistent with the principles of § 489.18). The contractor shall apply this policy to such applications. If, therefore, the provider/supplier/new owner submits the application with more than one EFT account or SPA, the contractor shall develop for a single EFT account or SPA (as applicable) consistent with the instructions in this chapter. If the provider/supplier/new owner fails to comply within 30 days, the contractor shall reject the application pursuant to 42 CFR § 424.525(a)(1).

C. Denied, Rejected, or Returned Changes

If, in the circumstances described above, the submitted EFT or SPA change is denied, rejected, or returned, the contractor shall:

- *Follow existing procedures in this chapter for denying, rejecting, or returning the change (e.g., sending letter). The existing EFT or SPA data as shown in PECOS will remain the same, and no consolidation occurs.*
- *If the denial, rejection, or return results in the expiration of the applicable time period for reporting the change (i.e., 90 days), the contractor shall e-mail its PEOG BFL notifying him/her of the denial, rejection, or return. PEOG will determine whether*

the provider's/supplier's billing privileges should be deactivated under § 424.540(a)(2) or revoked under § 424.535(a)(1) or (a)(9). PEOG will notify the contractor of its decision.

10.7 – Model Letters

(Rev. 11859; Issued: 02-16-23; Effective: 03-17-23; Implementation: 03-17-23)

The contractor shall use the following letters when rejecting, returning, approving or denying an application, or when revoking an entity's Medicare billing privileges. Any exceptions to this guidance shall be approved by the contractor's CMS Provider Enrollment & Oversight Group Business Function Lead (PEOG BFL), unless specified otherwise. The contractor shall document approval received by its PEOG BFL for QASP purposes.

A. Issuing Letters - Model Letter Guidance

All letters sent by contractors to providers and suppliers shall contain and/or adhere to the formats/requirements addressed in sections 10.7(A) and (B). Note, however, the following:

(i) For certified provider/supplier types and transactions that have formally "transitioned" as described in section 10.7.5.1, the requirements (e.g., data elements) of the model letters in section 10.7.5.1 take precedence over any contrary instruction in section 10.7. For example, if section 10.7 requires a data element that a specific letter in section 10.7.5.1 pertaining to the same enrollment transaction/situation does not, the section 10.7.5.1 letter requirements supersede the former. Likewise, if section 10.7 requires the removal/addition of language that is/is not in the applicable section 10.7.5.1 letter, the latter controls.

(ii) For certified provider/supplier types and transactions that have not transitioned (and except as otherwise stated in section 10.7 (e.g., subsection (A)(2)(n)), the contractor shall continue to follow the existing instructions in section 10.7 and utilize the letters in section 10.7.5.

1. General Guidance

(a) The CMS logo (2012 version) displayed per previous CMS instructions.

(b) The contractor's logo shall be displayed however the contractor deems appropriate. There are no restrictions on font, size, or location. The only restriction is that the contractor's logo must not conflict with the CMS logo.

(c) Excluding items in the header or footer, all text shall be written in Times New Roman 12-point font (with the exception of name and address information per USPS requirements).

(d) All dates in letters, except otherwise specified, shall be in the following format: month/dd/YYYY (e.g., January 26, 2012).

(e) Letters shall contain fill-in sections as well as static, or "boilerplate" sections. The fill-in sections are delineated by words in brackets in italic font in the model letters.

(f) The static sections shall be left as-is unless there is specific guidance for removing a section (e.g., removing a CAP section for certain denial and revocation reasons; removing state survey language for certain provider/supplier types that do not require a survey). If there is no guidance for removing a static section, the contractor must obtain approval from its PEOG BFL to modify or remove such a section.

2. Approval Letters

(a) Part A/B certified provider and supplier paper/web COI and revalidation approval recommended letters shall detail the recommended changes (e.g. practice location changed to 123 Main Street, Baltimore MD 21244).

(b) For COI and revalidation applications that do not require a tie-in or recommendation but require notification to the SOG Location as a cc, the contractor shall add the additional fields applicable to the letter (e.g., cc the state/SOG Location). The contractor should itemize the changes if it is beneficial to the SOG Location.

(c) Part A/B and DME provider and supplier paper/web COI and revalidation letters shall only list the section title (at the sub-section level) from the paper/web Form CMS-855 and Form CMS-20134 application (e.g., Correspondence Mailing Address, Final Adverse Legal Actions, Remittance Notices/Special Payments Mailing Address, etc.).

(d) If, as part of a revalidation, the provider/supplier only partially revalidates (i.e., a provider has multiple PTANs, and one PTAN is revalidated with the others end-dated), the contractor shall notate 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).

(e) If the provider is submitting a change as part of a voluntary termination application (e.g. special payment address, EFT, authorized official), the contractor shall enter the applicable fields into the Medicare Enrollment information table.

(f) Approval letters may include a generic provider enrollment signature and contact information (e.g. customer service line). However, all development letters shall include a provider enrollment analyst's name and phone number for provider/supplier contacts.

(g) Participation status shall only be included in initial and reactivation letters for Part B sole proprietors, Part B sole owners, any Part B organizations and DME suppliers. Change of information approval letters shall only include the participation status if it was changed as part of the application submission.

(h) The contractor shall add lines to the enrollment information tables on any reactivation letter if the provider/supplier has reactivated following non-response to a revalidation and enrollment information was changed on the application.

(i) The contractor shall enter an effective date on all change of information approval letters if a new PTAN is issued based on the changes (e.g., a new location is added to a new payment locality).

(j) The contractor shall add appeal rights to all change of information and revalidation approval letters if a new PTAN is issued based on the changes (e.g., a new location is added to a new payment locality; a new reassignment is created).

(k) If the provider/supplier is revalidating multiple reassignments to different groups, the contractor shall add additional lines to the grid to identify the separate groups and PTANs.

(l) If the provider/supplier revalidates both reassignments and one or more sole proprietorship locations, the contractor shall indicate on the appropriate letter that the approval covers the reassignments and sole proprietorship locations.

(m) In the Part B non-certified supplier letters, the contractor shall populate 42 CFR§ 424.205 for MDPP suppliers or § 424.516 for all other providers/suppliers with the following paragraph: "Submit updates and changes to your enrollment information

within the timeframes specified at [42 CFR § 424.516 or 42 CFR§ 424.205]. For more information on the reporting requirements, go to Medicare Learning Network Article SE1617."

(n) For all pre-transition and post-transition seller CHOWs (both HHA and non-HHA), the contractor shall use the "M. Approval – Seller CHOW (Part A/B Certified Org") letter in section 10.7.5.1 when voluntarily terminating the seller's enrollment in a 42 CFR § 489.18 CHOW (which includes mergers, acquisitions, and consolidations). The contractor shall use the effective date of the CHOW as the "Effective Date of Enrollment Termination" in the letter.

(o) The contractor shall remove the following language when issuing the Approval – Voluntary Termination (Part B Non-Certified Org or Part B Sole Owner) letter in section 10.7.6(V) for a Part B non-certified supplier: "Reassignments and any physician assistant employment arrangements are also deactivated", unless other active reassignments/employment arrangements exist on the enrollment.

3. Denial/Revocation Letters

(a) The contractor shall populate the fill-in sections with the appropriate information, such as primary regulatory citation, specific denial and revocation reasons, names/addresses, etc.

(b) The fill-in sections shall be indented ½ inch from the normal text of the letter.

(c) All specific or explanatory reasons shall appear in bold type and shall match the federal registry heading. This applies to headings. For example, if the revocation letter contains the following specific explanatory language, the heading should be in bold type and the explanation should be in normal type as shown in the excerpt below:

42 CFR § 424.535(a)(8)(i) – Abuse of Billing Privileges

Data analysis conducted on claims billed by [Dr. Ambassador], for dates of service [Month XX, XXXX], to [Month XX, XXXX], revealed that [Dr. Ambassador] billed for services provided to [XX] Medicare beneficiaries who were deceased on the purported date of service.

(d) There may be more than one primary reason listed.

(e) This subsection (A)(3)(e) applies to certified provider and certified supplier denial or revocation letters that meet both of the following requirements:

- The provider enrollment denial or revocation also requires the denial or termination of the corresponding provider or supplier agreement (e.g., Form CMS-1561, Form CMS-370, etc.)
- The SOG Location is responsible for handling the reconsideration/appeal of the provider/supplier agreement denial or termination.

If these requirements are met -- and notwithstanding any instruction to the contrary in this chapter -- the contractor shall insert the following language into the provider enrollment denial or revocation letter (preferably at the conclusion of the letter's discussion/outline of appeal rights):

"Note that the provider enrollment appeal rights addressed in this letter are unrelated to any appeal rights concerning the [denial or termination, as applicable] of your [provider or supplier, as applicable] agreement. The two processes are separate and distinct, and a successful appeal of your enrollment [denial or revocation, as applicable] does not

automatically restore your [provider or supplier] agreement. Any such restoration of the latter is handled by the Survey Operations Group Location and not by CMS' Provider Enrollment & Oversight Group."

4. Voluntary Terminations

If a provider/supplier (certified or non-certified) is voluntarily terminating their enrollment, the contractor shall use the applicable voluntary termination letter.

5. No PEOG Approval

The following letter revisions do not require prior PEOG BFL approval. (Notwithstanding the language in subsection 10.7(A)(i), this includes the letters in section 10.7.5.1 et seq.)

(a) If the contractor cannot format the enrollment information table as provided in these model letters, the contractor may provide the information in a similar non-table format.

(b) Placing a reference n umber or numbers between the provider/supplier address and the salutation. (For Internet-based PECOS applications, the contractor can include its document control number and the Web Tracking ID in this field.)

(c) The contractor shall enter "N/A" or leave blank a data element in an enrollment information table if said field is inapplicable (e.g., doing business as (DBA), effective date for changes).

(d) The contractor shall include the applicable PTAN and NPI for the application submission on the letter. If multiple PTANs or NPIs apply, the contractor should: (1) enter "multiple" in the PTAN and NPI fields; (2) copy and add additional PTAN/NPI rows to the enrollment information tables; or (3) attach a list of any and all PTAN and NPI combinations that apply in the letter.

(e) For individual revalidations in which multiple PTANs may be revalidating from multiple reassignments or individual associations, the contractor may also list the group's LBN and PTAN effective date in connection with the appropriate individual NPI-PTAN combinations. The contractor has flexibility in relaying these fields when multiplicities exist, ensuring they meet the template's reporting requirements.

(f) Appropriate documents attached to specific letters as needed.

(g) Placing language in any letter regarding self-service functions, such as the Provider Contact Center Interactive Voice Response (IVR) system and Electronic Data Interchange (EDI) enrollment process.

B. Sending Letters

The contractor shall note the following:

1. Except as stated otherwise in this chapter (e.g., certain applications from already-transitioned certified provider/supplier types), the contractor shall issue approval letters within 5 business days of approving the application in PECOS.

2. For all applications other than the Form CMS-855S, the contractor shall send development/approval letters, etc., to the contact person if one is listed. Otherwise, the contractor may send the letter to the provider/supplier at the e-mail, mailing address, or fax provided in the correspondence address or special payments address sections.

3. The contractor may insert an attention field with the contact's name as part of the mailing address, but the letter should still be addressed to the provider/supplier. *As applicable, t*he contractor shall continue to send letters to the *DMEPOS* supplier's correspondence address until the automated process can be updated to include the contact person as a recipient of the letters.

4. If the provider/supplier submits two Form CMS-855Rs concurrently, two separate approval letters shall be issued (one for each group reassignments).

5. For initial, change of information, revalidation, and voluntary termination applications submitted by sole owners, the contractor should issue one approval letter. However, the Medicare enrollment information table shall distinctly list the individual and sole owner information.

6. If, as part of revalidation, a physician assistant is adding and terminating an employment relationship, one letter shall be issued (approving the revalidation). However, the termination and additional employment relationship shall be noted in the approval letter.

7. The contractor shall issue all denial and revocation letters via certified mail.

8. Notwithstanding any other instruction to the contrary in this chapter, the contractor shall copy via email the applicable accrediting organization (AO) (along with, as currently required, the state agency) on a recommendation for approval letter or final provider/supplier notification letter (e.g., final approval, denial, etc.) letter if: (1) the provider/supplier lists the AO on the Form CMS-855 or ADR application; (2) PEOG notifies the contractor of the AO's involvement; or (3) the contractor otherwise becomes aware of the provider/supplier's AO affiliation.

10.7.7 – Application Return and Rejection Model Letters

(Rev. 11859; Issued: 02-16-23; Effective: 03-17-23; Implementation: 03-17-23)

A. Returned Application Letter

[month] [day], [year]

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

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

Dear [Provider/Supplier Name]:

Your Medicare enrollment application(s) was received on [date]. We are closing this request and returning your application(s) for the following reason(s):

[List all reasons for return]

If you would like to resubmit an application, you must complete a new Medicare enrollment application(s). Please address the above issues as well as sign and date the new certification statement page on your resubmitted application(s).

Providers and suppliers can apply to enroll in the Medicare program using one of the following two methods:

1. Internet-based Provider Enrollment, Chain and Organization System (PECOS). Go to: https://pecos.cms.hhs.gov/pecos/login.do.

2. Paper application process: Download and complete the Medicare enrollment application(s) at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/EnrollmentApplications.html.

Please return the completed application(s) to:

[Name of MAC]
[Address]
[City], ST [Zip]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name]
[Title]
[Company]

B. Model Rejection Letter

[month] [day], [year]

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

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

Dear [Provider/Supplier Name]:

We received your Medicare enrollment application(s) on [Receipt Date]. We are rejecting your application(s) for the following reason(s):

[List all reasons for rejection]

If you would like to resubmit an application, you must complete a new Medicare enrollment application(s). Please address the above issues as well as sign and date the new certification statement page on your resubmitted application(s).

In compliance with Federal regulations found at 42 CFR §424.525, providers and suppliers are required to submit complete application(s) and all supporting documentation within 30 calendar days from the postmark date of the contractor request for missing/incomplete information.

Providers and suppliers can apply to enroll in the Medicare program using one of the following two methods:

1. Internet-based Provider Enrollment, Chain and Organization System (PECOS). Go to: https://pecos.cms.hhs.gov/pecos/login.do.

2. Paper application process: Download and complete the Medicare enrollment application(s) at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/EnrollmentApplications.html.

Please return the completed application(s) to:

[Name of MAC]
[Address]
[City], ST [Zip]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name]
[Title]
[Company]

C. Rejection Letter for Locations That Do Not Meet the Distance Requirements

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

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

Dear [Provider/Supplier Name]:

We received your Medicare enrollment application(s) to add a new provider-based location to your Critical Access Hospital enrollment on [date]. We are rejecting your application because the *[enter the office that made the decision]* has found that your new location does not meet distance requirements found in 42 CFR § 485.610(e)(2).

Please refer to communications from the *[enter the office that made the decision]* for instructions for your next steps regarding the new provider-based location.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name]
[Title]
[Company]

10.7.8 – Denial Model Letters

(Rev. 11859; Issued: 02-16-23; Effective: 03-17-23; Implementation: 03-17-23)

A. Denial Letter Guidance

The contractor must submit one or more of *the* denial citations as found in Section *10.4.2 et seq.* of this chapter into the appropriate section on the Model Denial Letter. Only the CFR citation and a short heading shall be cited for the primary denial reason.

- The contractor may submit one or more denial reason, as appropriate. The denial reason(s) should state sufficient details so it is clear as to why the provider or supplier is being denied.

- Specific Denial Reasons may contain one or more of the following items:

    - A specific regulatory (CFR) citation.

    - Dates (of actions, suspensions, convictions, receipt of documents, etc.)

    - Pertinent details of action(s)

    DMEPOS supplier-only language. All denial letters for *DMEPOS suppliers* shall replace the 1st paragraph of the model denial letter with the following text:

    Your application to enroll in Medicare is denied. After reviewing your submitted application document(s), it was determined that per 42 CFR § 405.800, 42 CFR § 424.57, and 42 CFR § 498.22, that you do not meet the conditions of enrollment or meet the requirements to qualify as a Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) provider or supplier for the following reason(s):

    (Exclusions and sanctions – the following two sentences should be REMOVED for all denial letters that DO NOT involve an exclusion or sanction action:

    You may not appeal through this process the merits of any exclusion by another federal agency. Any further permissible administrative appeal involving the merits of such exclusion must be filed with the federal agency that took the action.)

For IDTF, DMEPOS, and MDPP providers and suppliers, each regulatory citation needs to be listed along with the specific regulatory language. For IDTF, the standards are found in 42 CFR § 410.33(g). For DMEPOS providers and suppliers, the standards are found in 42 CFR *§* 424.57*(*c)*(*1) through *(*30*)*. For MDPP suppliers, the standards are found in 42 CFR § 424.205(d).

If a provider is being added to the CMS Preclusion List, the following should be inserted to the denial letter (should PEOG instruct the contractor to do so:

> The Centers for Medicare & Medicaid Services (CMS) has been made aware of [Provider Name]'s [Date], felony conviction, as defined in 42 C.F.R. § 1001.2, for [reason] in violation of [Code] in the Court Name]. After reviewing the specific facts and circumstances surrounding [Jane Doe]'s felony conviction, CMS has determined that [Provider Name]'s felony conviction is detrimental to the best interests of the Medicare program and its beneficiaries.

Additionally, [Provider Name] will be placed on the CMS Preclusion List because [he/she] has been convicted of a felony, as described above, under Federal or State law, within the previous 10 years, that CMS deems detrimental to the best interests of the Medicare program. CMS may take this action regardless of whether you are or were enrolled in the Medicare program. This action is being taken pursuant to 42 C.F.R. §§ 422.2, 422.222, 423.100, and 423.120(c)(6).

The effective date of your inclusion on the Preclusion List is dependent upon the submission or non-submission of a reconsideration request (see below). If you do submit a reconsideration request and your inclusion on the Preclusion List is upheld, you will be added to the Preclusion List on the date of the reconsideration decision. If you do not submit a reconsideration request, you will be included on the Preclusion List 65 days after the date of this letter.

During the time period that your name will be included on the Preclusion List as listed above, any claims you submit for health care items or services furnished under a Medicare Advantage (MA) benefit may be denied. Additionally, any pharmacy claims submitted for Medicare Part D drugs that you prescribe may be rejected or denied. This means that your patients may not be able to receive coverage of their prescriptions using their Part D benefit at the pharmacy.

The below appeal rights apply to both your denial and preclusion. If you choose to appeal, you **must** file an appeal to the denial and preclusion jointly.

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination.

Reconsideration requests must:

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
    - If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
    - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.
    - Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her behalf.

Providers and suppliers may:

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during

the administrative appeals process unless an ALJ allows additional information to be submitted.

- Include an email address if you want to receive correspondence regarding your appeal via email.

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

Centers for Medicare & Medicaid Services
Provider Enrollment & Oversight Group
Attn: Division of Compliance and Appeals
7500 Security Boulevard
Mailstop AR-18-50
Baltimore, MD 21244-1850

Or emailed to:

ProviderEnrollmentAppeals@cms.hhs.gov

B. Model Denial Letter

[month] [day], [year]

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

Reference # (Contractor Control Number or NPI)

Dear [Provider/Supplier Name]:

Your application to enroll in Medicare is denied for the following reason(s):

xx CFR §xxx.(x) [heading]
[Specific reason]

xx CFR §xxx.(x) [heading]
[Specific reason]

Right to Submit a Corrective Action Plan (CAP) and Reconsideration Request:

Corrective Action Plan: (Only if denied under 42 C.F.R. § 424.530(a)(1))

You may submit a corrective action plan (CAP) in response to the denial of an enrollment application under 42 C.F.R. § 424.530(a)(1). You may also request a reconsideration (described below). If your enrollment application was denied under authorities other than 42 C.F.R. § 424.530(a)(1), you may **only** submit a reconsideration request in response to those denial bases.

The CAP is an opportunity to demonstrate that you have corrected the deficiencies identified above and thereby, establish your eligibility to enroll in the Medicare program.

(Optional Coversheet sentence: [To facilitate the processing of your CAP, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.]) The CAP must--

- Be received in writing within 35 calendar days of the date of this letter and mailed to the address below or emailed to the address below;
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
    - If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
    - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.
    - Authorized or delegated officials for groups cannot sign and submit a CAP on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her behalf.
- Provide evidence to demonstrate that you are in compliance with Medicare requirements.

Please note that CAPs may not be appealed further to the Departmental Appeals Board. Further appeal rights do exist for reconsideration requests (described below). CAP requests should be sent to:

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

[Name of MAC]
[Address]
[City], ST [Zip]

or

Centers for Medicare & Medicaid Services
Center for Program Integrity
Provider Enrollment & Oversight Group
Attn: Division of Compliance and Appeals
7500 Security Boulevard
Mailstop AR-18-50
Baltimore, MD 21244-1850

Or emailed to:

[Insert MAC email address] or [ProviderEnrollmentAppeals@cms.hhs.gov]

Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. (Optional Coversheet sentence [To facilitate the processing of your reconsideration request, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.])

Reconsideration requests must--

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for

disagreement.

- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.

    - If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
    - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.
    - Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her behalf.

Providers and suppliers may--

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.
- Include an email address if you want to receive correspondence regarding your appeal via email.
- (If denied under 42 C.F.R. § 424.530(a)(2)) Please note that you may not appeal through this process the merits of any exclusion by another Federal agency. Any further permissible administrative appeal involving the merits of such exclusion must be filed with the Federal agency that took the action.

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

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

[Name of MAC]
[Address]
[City], ST [Zip]

or

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

Or emailed to:

[Insert MAC email address] or [ProviderEnrollmentAppeals@cms.hhs.gov]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name]
[Title]
[Company]

C. Denial Example Letters

Note that each example contains appeal rights for both CMS and the MAC, regardless of the example reason, so that the contractors may include the appropriate appeal address based on the provider or supplier type that has been denied.

1. Discipline Not Eligible Example

[month] [day], [year]

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

Reference # (Contractor Control Number or NPI)

Dear [Provider/Supplier Name]:

Your application to enroll in Medicare is denied for the following reason(s):

42 CFR §424.530(a)(1) – Not in Compliance with Medicare Requirements
There is no statutory or regulatory basis which permits a Marriage and Family Therapist to enroll or receive payment in the Medicare Program.

Right to Submit a Corrective Action Plan (CAP) and Reconsideration Request:

Corrective Action Plan: (Only if denied under 42 C.F.R. § 424.530(a)(1))

You may submit a corrective action plan (CAP) in response to the denial of an enrollment application under 42 C.F.R. § 424.530(a)(1). You may also request a reconsideration (described below). If your enrollment application was denied under authorities other than 42 C.F.R. § 424.530(a)(1), you may **only** submit a reconsideration request in response to those denial bases.

The CAP is an opportunity to demonstrate that you have corrected the deficiencies identified above and thereby, establish your eligibility to enroll in the Medicare program. (Optional Coversheet sentence: [To facilitate the processing of your CAP, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.]) The CAP must--

- Be received in writing within 35 calendar days of the date of this letter and mailed to the address below or emailed to the address below;
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
    - If the authorized representative is an attorney, the attorney's statement that he

or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
    - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.
    - Authorized or delegated officials for groups cannot sign and submit a CAP on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her behalf.
- Provide evidence to demonstrate that you are in compliance with Medicare requirements.

Please note that CAPs may not be appealed further to the Departmental Appeals Board. Further appeal rights do exist for reconsideration requests (described below). CAP requests should be sent to:

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

[Name of MAC]
[Address]
[City], ST [Zip]

or

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Provider Enrollment & Oversight Group
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Or emailed to:

[Insert MAC email address]or [ProviderEnrollmentAppeals@cms.hhs.gov]

Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. (Optional Coversheet sentence [To facilitate the processing of your reconsideration request, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.])

Reconsideration requests must--

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
    - If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
    - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the

appointment of its representative with the submission of the reconsideration request.
    - Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her behalf.

Providers and suppliers may--

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.
- Include an email address if you want to receive correspondence regarding your appeal via email.
- (If denied under 42 C.F.R. § 424.530(a)(2)) Please note that you may not appeal through this process the merits of any exclusion by another Federal agency. Any further permissible administrative appeal involving the merits of such exclusion must be filed with the Federal agency that took the action.

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

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

Or emailed to:

[Insert MAC email address]or [ProviderEnrollmentAppeals@cms.hhs.gov]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,
[Name]

[Title]
[Company]

2. Criteria for Eligible Discipline Not Met Example

[month] [day], [year]

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

Reference # (Contractor Control Number or NPI)

Dear [Provider/Supplier Name]:

Your application to enroll in Medicare is denied for the following reason(s):

42 CFR §424.530(a)(1) - Not in Compliance with Medicare Requirements
Per 42 CFR §410.75(b)(1)(i), the provider or supplier is not certified by a recognized national certifying body that has established standards for nurse practitioners.

Right to Submit a Corrective Action Plan (CAP) and Reconsideration Request:

Corrective Action Plan: (Only if denied under 42 C.F.R. § 424.530(a)(1))

You may submit a corrective action plan (CAP) in response to the denial of an enrollment application under 42 C.F.R. § 424.530(a)(1). You may also request a reconsideration (described below). If your enrollment application was denied under authorities other than 42 C.F.R. § 424.530(a)(1), you may **only** submit a reconsideration request in response to those denial bases.

The CAP is an opportunity to demonstrate that you have corrected the deficiencies identified above and thereby, establish your eligibility to enroll in the Medicare program. (Optional Coversheet sentence: [To facilitate the processing of your CAP, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.]) The CAP must--

- Be received in writing within 35 calendar days of the date of this letter and mailed to the address below or emailed to the address below;
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
    - If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
    - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.
    - Authorized or delegated officials for groups cannot sign and submit a CAP on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her behalf.
- Provide evidence to demonstrate that you are in compliance with Medicare requirements.

Please note that CAPs may not be appealed further to the Departmental Appeals Board. Further appeal rights do exist for reconsideration requests (described below). CAP requests should be sent to:

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

[Name of MAC]
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Centers for Medicare & Medicaid Services
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7500 Security Boulevard
Mailstop AR-18-50
Baltimore, MD 21244-1850

Or emailed to:

[Insert MAC email address]or [ProviderEnrollmentAppeals@cms.hhs.gov]

Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. (Optional Coversheet sentence [To facilitate the processing of your reconsideration request, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.])

Reconsideration requests must--

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
    - If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
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    - Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her behalf.

Providers and suppliers may--

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your

request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.
- Include an email address if you want to receive correspondence regarding your appeal via email.
- (If denied under 42 C.F.R. § 424.530(a)(2)) Please note that you may not appeal through this process the merits of any exclusion by another Federal agency. Any further permissible administrative appeal involving the merits of such exclusion must be filed with the Federal agency that took the action.

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

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

[Name of MAC]
[Address]
[City], ST [Zip]

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Baltimore, MD 21244-1850

Or emailed to:

[Insert MAC email address]or [ProviderEnrollmentAppeals@cms.hhs.gov]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,
[Name]

[Title]
[Company]

3. Provider Standards Not Met Example

[month] [day], [year]

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

Reference # (Contractor Control Number or NPI)

Dear IDTF Services, Inc.:

Your application to enroll in Medicare is denied for the following reason(s):

42 CFR §424.530(a)(5) - On-site Review - Requirements Not Met
Specifically, the following standards were not met:

42 CFR §410.33(g) 4 - Have all applicable diagnostic testing equipment available at the physical site excluding portable diagnostic testing equipment. A catalog of portable diagnostic equipment, including diagnostic testing equipment serial numbers, must be maintained at the physical site. In addition, portable diagnostic testing equipment must be available for inspection within two business days of a CMS inspection request. The IDTF must maintain a current inventory of the diagnostic testing equipment, including serial and registration numbers, provide this information to the designated fee-for-service contractor upon request, and notify the contractor of any changes in equipment within 90 days.

42 CFR §410.33(g) 9 - Openly post these [IDTF] standards for review by patients and the public

42 CFR §410.33(g) 11 - Have its testing equipment calibrated and maintained per equipment instructions and in compliance with applicable manufacturers suggested maintenance and calibration standards.

42 CFR §410.33(g) 12 - Have technical staff on duty with the appropriate credentials to perform tests. The IDTF must be able to produce the applicable Federal or State licenses or certifications of the individuals performing these services.

Right to Submit a Corrective Action Plan (CAP) and Reconsideration Request:

Corrective Action Plan: (Only if denied under 42 C.F.R. § 424.530(a)(1))

You may submit a corrective action plan (CAP) in response to the denial of an enrollment application under 42 C.F.R. § 424.530(a)(1). You may also request a reconsideration (described below). If your enrollment application was denied under authorities other than 42 C.F.R. § 424.530(a)(1), you may **only** submit a reconsideration request in response to those denial bases.

The CAP is an opportunity to demonstrate that you have corrected the deficiencies identified above and thereby, establish your eligibility to enroll in the Medicare program. (Optional Coversheet sentence: [To facilitate the processing of your CAP, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.]). The CAP must--

- Be received in writing within 35 calendar days of the date of this letter and mailed to the address below or emailed to the address below;
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
    - If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
    - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.
    - Authorized or delegated officials for groups cannot sign and submit a CAP on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to

act on his/her behalf.

- Provide evidence to demonstrate that you are in compliance with Medicare requirements.

Please note that CAPs may not be appealed further to the Departmental Appeals Board. Further appeal rights do exist for reconsideration requests (described below). CAP requests should be sent to:

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

[Name of MAC]
[Address]
[City], ST [Zip]

or

Centers for Medicare & Medicaid Services
Center for Program Integrity
Provider Enrollment & Oversight Group
Attn: Division of Compliance and Appeals
7500 Security Boulevard
Mailstop AR-18-50
Baltimore, MD 21244-1850

Or emailed to:

[Insert MAC email address]or [ProviderEnrollmentAppeals@cms.hhs.gov]

Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. (Optional Coversheet sentence [To facilitate the processing of your reconsideration request, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.])

Reconsideration requests must--

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
    - If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
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    - Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her behalf.

Providers and suppliers may--

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.
- Include an email address if you want to receive correspondence regarding your appeal via email.
- (If denied under 42 C.F.R. § 424.530(a)(2)) Please note that you may not appeal through this process the merits of any exclusion by another Federal agency. Any further permissible administrative appeal involving the merits of such exclusion must be filed with the Federal agency that took the action.

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

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

[Name of MAC]
[Address]
[City], ST [Zip]

or

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Center for Program Integrity
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Baltimore, MD 21244-1850

Or emailed to:

[Insert MAC email address]or [ProviderEnrollmentAppeals@cms.hhs.gov]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,
[Name]

[Title]
[Company]

4. Business Type Not Met Example

[month] [day], [year]

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

Reference # (Contractor Control Number or NPI)

Dear [Provider/Supplier Name]:
Your application to enroll in Medicare is denied for the following reason(s):

42 CFR §424.530(a)(1) - Not in Compliance with Medicare Requirements
42 CFR §410.62(c)(ii) states that speech language pathologists in private practice must be engaged in one of the following practice types if allowed by State and local law: (A) An unincorporated solo practice; (B) An unincorporated partnership or unincorporated group practice; (C) An employee in an unincorporated solo practice, partnership, or group practice, or a professional corporation or other incorporated speech-language pathology practice; (D) An employee of a physician group (includes certain Non-Physician Practitioners [NPPs], as appropriate); or (E) An employee of a group that is not a professional corporation.

Your current private practice status is an incorporated solo practice; therefore, you do not qualify as a Medicare provider or supplier.

Right to Submit a Corrective Action Plan (CAP) and Reconsideration Request:

Corrective Action Plan: (Only if denied under 42 C.F.R. § 424.530(a)(1))

You may submit a corrective action plan (CAP) in response to the denial of an enrollment application under 42 C.F.R. § 424.530(a)(1). You may also request a reconsideration (described below). If your enrollment application was denied under authorities other than 42 C.F.R. § 424.530(a)(1), you may **only** submit a reconsideration request in response to those denial bases.

The CAP is an opportunity to demonstrate that you have corrected the deficiencies identified above and thereby, establish your eligibility to enroll in the Medicare program. (Optional Coversheet sentence: [To facilitate the processing of your CAP, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.]). The CAP must--

- Be received in writing within 35 calendar days of the date of this letter and mailed to the address below or emailed to the address below;
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
    - If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
    - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.
    - Authorized or delegated officials for groups cannot sign and submit a CAP on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her behalf.
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(Insert correct address based on whether the MAC or CMS is responsible for reviewing the CAP)

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Mailstop AR-18-50
Baltimore, MD 21244-1850

Or emailed to:

[Insert MAC email address] or [ProviderEnrollmentAppeals@cms.hhs.gov]

Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. (Optional Coversheet sentence [To facilitate the processing of your reconsideration request, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.])

Reconsideration requests must--

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
    - If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
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Providers and suppliers may--

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.
- Include an email address if you want to receive correspondence regarding your appeal

via email.

- (If denied under 42 C.F.R. § 424.530(a)(2)) Please note that you may not appeal through this process the merits of any exclusion by another Federal agency. Any further permissible administrative appeal involving the merits of such exclusion must be filed with the Federal agency that took the action.

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The reconsideration request should be sent to:

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[Name of MAC]
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Baltimore, MD 21244-1850

Or emailed to:

[Insert MAC email address]or [ProviderEnrollmentAppeals@cms.hhs.gov]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,
[Name]

[Title]
[Company]

5. Existing or Delinquent Overpayments Example

[month] [day], [year]

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

Reference # (Contractor Control Number or NPI)

Dear [Provider/Supplier Name]:

Your application to enroll in Medicare is denied for the following reason(s):

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

The current owner (as defined in § 424.502), physician or non-physician practitioner has an existing overpayment at the time of filing an enrollment application.

Dates: (enter date of existing or delinquent overpayment period)

Pertinent details of action(s) (Whether the person or entity is on a Medicare-approved plan of repayment of payments are currently being offset: Whether the overpayment is currently being appealed; the reason for the overpayment)

Right to Submit a Corrective Action Plan (CAP) and Reconsideration Request:

Corrective Action Plan: (Only if denied under 42 C.F.R. § 424.530(a)(1))

You may submit a corrective action plan (CAP) in response to the denial of an enrollment application under 42 C.F.R. § 424.530(a)(1). You may also request a reconsideration (described below). If your enrollment application was denied under authorities other than 42 C.F.R. § 424.530(a)(1), you may **only** submit a reconsideration request in response to those denial bases.

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[Insert MAC email address]or [ProviderEnrollmentAppeals@cms.hhs.gov]

Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. (Optional Coversheet sentence [To facilitate the processing of your reconsideration request, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.])

Reconsideration requests must--

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
    - If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
    - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.
    - Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her behalf.

Providers and suppliers may--

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.
- Include an email address if you want to receive correspondence regarding your appeal via email.
- (If denied under 42 C.F.R. § 424.530(a)(2)) Please note that you may not appeal through this process the merits of any exclusion by another Federal agency. Any further permissible administrative appeal involving the merits of such exclusion must be filed with the Federal agency that took the action.

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

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

[Name of MAC]
[Address]
[City], ST [Zip]

or

Centers for Medicare & Medicaid Services
Center for Program Integrity
Provider Enrollment & Oversight Group
Attn: Division of Compliance and Appeals
7500 Security Boulevard
Mailstop AR-18-50
Baltimore, MD 21244-1850

Or emailed to:

[Insert MAC email address]or [ProviderEnrollmentAppeals@cms.hhs.gov]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,
[Name]

[Title]
[Company]

6. MDPP Supplier Standards Not Met – Ineligible Coach Example

[month] [day], [year]

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

Reference # (Contractor Control Number or NPI)

Dear [Provider/Supplier Name]:

Your application to enroll in Medicare is denied for the following reason(s):
42 CFR §424.530(a)(1) - Not in Compliance with Medicare Requirements

Specifically, the following standards were not met:

42 CFR §424.205(d)(3) - The MDPP supplier must not include on the roster of coaches nor permit MDPP services to be furnished by any individual coach who meets any of ineligibility criteria.
42 CFR §424.205(e)(v)(a) specifies that an individual with a state or federal felony conviction in the previous 10 years of any crime against persons, such as murder, rape, assault, and other similar crimes, would not meet the eligibility criteria to be an MDPP coach.

The following coach included on Section 7 of your Form CMS-20134 or its electronic equivalent meets this ineligibility criteria:

John B. Doe | DOB: June 19, 1991 | NPI: 1234567

Please see attached documentation of the felony conviction.

Right to Submit a Corrective Action Plan (CAP) and Reconsideration Request:

Corrective Action Plan: (Only if denied under 42 C.F.R. § 424.530(a)(1))

You may submit a corrective action plan (CAP) in response to the denial of an enrollment application under 42 C.F.R. § 424.530(a)(1). You may also request a reconsideration (described below). If your enrollment application was denied under authorities other than 42 C.F.R. § 424.530(a)(1), you may **only** submit a reconsideration request in response to those denial bases.

The CAP is an opportunity to demonstrate that you have corrected the deficiencies identified above and thereby, establish your eligibility to enroll in the Medicare program. (Optional Coversheet sentence: [To facilitate the processing of your CAP, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.]). The CAP must--

- Be received in writing within 35 calendar days of the date of this letter and mailed to the address below or emailed to the address below;
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
    - If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
    - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.
    - Authorized or delegated officials for groups cannot sign and submit a CAP on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her behalf.
- Provide evidence to demonstrate that you are in compliance with Medicare requirements.

Please note that CAPs may not be appealed further to the Departmental Appeals Board. Further appeal rights do exist for reconsideration requests (described below). CAP requests should be sent to:

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

[Name of MAC]
[Address]
[City], ST [Zip]

or

Centers for Medicare & Medicaid Services
Center for Program Integrity
Provider Enrollment & Oversight Group
Attn: Division of Compliance and Appeals
7500 Security Boulevard
Mailstop AR-18-50
Baltimore, MD 21244-1850

Or emailed to:

[Insert MAC email address] or [ProviderEnrollmentAppeals@cms.hhs.gov]

Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. (Optional Coversheet sentence [To facilitate the processing of your reconsideration request, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.])

Reconsideration requests must--

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
    - If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
    - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.
    - Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her behalf.

Providers and suppliers may--

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.
- Include an email address if you want to receive correspondence regarding your appeal via email.
- (If denied under 42 C.F.R. § 424.530(a)(2)) Please note that you may not appeal through this process the merits of any exclusion by another Federal agency. Any further permissible administrative appeal involving the merits of such exclusion must be filed with the Federal agency that took the action.

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

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

[Name of MAC]
[Address]
[City], ST [Zip]

or

Centers for Medicare & Medicaid Services
Center for Program Integrity
Provider Enrollment & Oversight Group
Attn: Division of Compliance and Appeals
7500 Security Boulevard
Mailstop AR-18-50
Baltimore, MD 21244-1850

Or emailed to:

[Insert MAC email address]or [ProviderEnrollmentAppeals@cms.hhs.gov]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,
[Name]

[Title]
[Company]

10.7.9 – Revocation Letters

(Rev. 11859; Issued: 02-16-23; Effective: 03-17-23; Implementation: 03-17-23)

A. Revocation Letter Guidance

The contractor--

- Must submit one or more of the Primary Revocation Reasons as found in section 10.*4.7.3* into the appropriate section on the specific Revocation Letter. Only the CFR citation and a short heading shall be cited for the primary revocation reason.

- Shall include sufficient details to support the reason for the provider or supplier's revocation;

- Shall issue all revocation letters via certified letter, per regulations found in 42 CFR 405.800(b)(1), and;

- Shall issue two revocation letters to any solely owned organizations, one for the individual and the other for the organization.

B. Model Revocation Letters

1. Revocation Example - Letter *for DMEPOS Suppliers*

[month] [day], [year]

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

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

Certified mail number: [number]
Returned receipt requested

Dear [Supplier Name]:

The purpose of this letter is to inform you that pursuant to 42 CFR §§ 405.800, 424.57(x), 424.535(g), and 424.535(a)[(x)], your Medicare supplier number [xxxxxxxxxx] for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)

[will be revoked effective 30 days from the postmarked date of this letter]

[is revoked. The effective date of this revocation has been made retroactive to [month] [day], [year], which is the date [revocation reason]]

Pursuant to 42 CFR §424.535(c), the supplier is barred from re-enrolling for a period of [number of years] year(s) in the Medicare program from the effective date of the revocation. In order to re-enroll, you must meet all requirements for your supplier type.

[The Supplier Audit and Compliance Unit (SACU) reviewed and evaluated the documents you submitted in response to the developmental letter dated [date]. This letter allowed you to demonstrate your full compliance with the DMEPOS supplier standards and/or to correct the deficient compliance requirement(s).]

[The Supplier Audit and Compliance Unit (SACU) has not received a response to the developmental letter sent to you on [date]. This letter allowed you to demonstrate your full compliance with the DMEPOS supplier standards and/or to correct the deficient compliance requirement(s)]

[[Contractor Name] has not received a response to the developmental letter sent to you on [date] informing you that the request for a hardship exception for the required application fee was denied. The notification afforded you the opportunity to pay the mandatory application fee for processing your enrollment application and an appeal period which you did not select.]

[[Contractor Name] has not received a response to the developmental letter sent to you on [date] informing you that the application fee was not paid at the time you filed *the Form* CMS-855S enrollment application. The 30day notification afforded you the opportunity to pay the mandatory application fee for processing your enrollment application]

We have determined that you are not in compliance with the supplier standards noted below:

42 CFR §424.57(c) [1-30] [Insert the specific performance standard not met]

Section 1834(j) of the Social Security Act states that, with the exception of medical equipment and supplies furnished incident to a physician's service, no payment may be made by Medicare for items furnished by a supplier unless the supplier has a valid Medicare billing number. Therefore, any expenses for items you supply to a Medicare beneficiary on or after the effective date of the revocation of your billing numbers are your responsibility and not the beneficiary's, unless you have proof that you have notified the beneficiary in accordance with section 1834 (a)(A)(ii) of the Social Security Act and the beneficiary has agreed to take financial responsibility if the items you supply are not covered by Medicare. You will be required to refund on a timely basis to the beneficiary (and will be liable to the beneficiary for) any amounts collected from the beneficiary for such items. If you fail to refund the

beneficiary as required under 1834 (j) (4) and 1879(h) of the Social Security Act, you may be liable for Civil Monetary penalties.

You may not appeal through this process the merits of any exclusion by another Federal agency. Any further permissible administrative appeal involving the merits of such exclusion must be filed with the Federal agency that took the action.

Right to Submit a Corrective Action Plan (CAP) and Reconsideration Request:

Corrective Action Plan: (Only if revoked under 42 C.F.R. § 424.535(a)(1))

You may submit a corrective action plan (CAP) in response to an enrollment revocation under 42 C.F.R. § 424.535(a)(1). You may also request a reconsideration (described below). If your enrollment was revoked under authorities other than 42 C.F.R. § 424.535(a)(1), you may **only** submit a reconsideration request in response to those denial bases.

The CAP is an opportunity to demonstrate that you have corrected the deficiencies identified above and thereby, establish your eligibility to enroll in the Medicare program. (Optional Coversheet sentence: [To facilitate the processing of your CAP, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.]). The CAP must--

- Be received in writing within 35 calendar days of the date of this letter and mailed to the address below or emailed to the address below;
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
    - If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
    - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.
    - Authorized or delegated officials for groups cannot sign and submit a CAP on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her behalf.
- Provide evidence to demonstrate that you are in compliance with Medicare requirements.

Please note that CAPs may not be appealed further to the Departmental Appeals Board. Further appeal rights do exist for reconsideration requests (described below). CAP requests should be sent to:

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

[Name of MAC]
[Address]
[City], [ST] [Zip]

or

Centers for Medicare & Medicaid Services
Center for Program Integrity
Provider Enrollment & Oversight Group
Attn: Division of Provider Enrollment Appeals
7500 Security Boulevard
Mailstop AR-19-51

Baltimore, MD 21244-1850

Or emailed to:

[Insert MAC email address] or [ProviderEnrollmentAppeals@cms.hhs.gov]

Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. (Optional Coversheet sentence [To facilitate the processing of your reconsideration request, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.])

Reconsideration requests must--

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
    - If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
    - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.
    - Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her behalf.

Providers and suppliers may--

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.
- Include an email address if you want to receive correspondence regarding your appeal via email.
- (If revoked under 42 C.F.R. § 424.535(a)(2)) Please note that you may not appeal through this process the merits of any exclusion by another Federal agency. Any further permissible administrative appeal involving the merits of such exclusion must be filed with the Federal agency that took the action.

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

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

[Name of MAC] [Address] [City], [ST] [Zip]	or	Centers for Medicare & Medicaid Services Center for Program Integrity Provider Enrollment & Oversight Group Attn: Division of Provider Enrollment Appeals 7500 Security Boulevard Mailstop AR-19-51 Baltimore, MD 21244-1850

Or emailed to:

[Insert MAC email address] or [ProviderEnrollmentAppeals@cms.hhs.gov]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name]
[Title]
[Company]

2. Model Revocation Letter for Part B Suppliers and Certified Providers and Suppliers

[Month] [day], [year]

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

Reference # (Contractor Control Number or NPI)

Dear [Provider/Supplier Name]:

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

xx CFR §xxx.(x) [heading]
[Specific reason]

xx CFR §xxx.(x) [heading]
[Specific reason]

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

Right to Submit a Corrective Action Plan (CAP) and Reconsideration Request:

Corrective Action Plan: (Only if revoked under 42 C.F.R. § 424.535(a)(1))

You may submit a corrective action plan (CAP) in response to the revocation of Medicare billing privileges under 42 C.F.R. § 424.535(a)(1). You may also request a reconsideration

(described below). If your Medicare billing privileges were revoked under authorities other than 42 C.F.R. § 424.535(a)(1), you may **only** submit a reconsideration request in response to those revocation bases.

The CAP is an opportunity to demonstrate that you have corrected the deficiencies identified above and thereby, establish your eligibility to maintain enrollment in the Medicare program. (Optional Coversheet sentence [To facilitate the processing of your CAP, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.]). The CAP must--

- Be received in writing within 35 calendar days of the date of this letter and mailed or emailed to the address below;

- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.

    - If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.

    - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.

    - Authorized or delegated officials for groups cannot sign and submit a CAP on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her behalf.

- Provide evidence to demonstrate that you are in compliance with Medicare requirements.

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

The CAP should be sent to:

[Name of MAC]
[Address]
[City], [ST] [Zip]

or

Centers for Medicare & Medicaid Services
Center for Program Integrity
Provider Enrollment & Oversight Group
Attn: Division of Provider Enrollment Appeals
7500 Security Boulevard
Mailstop AR-19-51
Baltimore, MD 21244-1850

Or emailed to:

[Insert MAC email address] or [ProviderEnrollmentAppeals@cms.hhs.gov]

Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. (Optional Coversheet sentence [To facilitate the processing of your reconsideration request, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.])

Reconsideration requests must--

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.

    - If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
    - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.
    - Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her behalf.

Providers and suppliers may--

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.
- Include an email address if you want to receive correspondence regarding your appeal via email.
- (If revoked under 42 C.F.R. § 424.535(a)(2)) Please note that you may not appeal through this process the merits of any exclusion by another Federal agency. Any further permissible administrative appeal involving the merits of such exclusion must be filed with the Federal agency that took the action.

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

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

[Name of MAC]
[Address]
[City], [ST] [Zip]

or

Centers for Medicare & Medicaid Services
Center for Program Integrity
Provider Enrollment & Oversight Group
Attn: Division of Provider Enrollment Appeals
7500 Security Boulevard
Mailstop AR-19-51
Baltimore, MD 21244-1850

Or emailed to:

[Insert MAC email address] or [ProviderEnrollmentAppeals@cms.hhs.gov]

Pursuant to 42 CFR §424.535(c), CMS is establishing a re-enrollment bar for a period of [Insert amount of time] that shall begin 30 days after the postmark date of this letter. This re-enrollment bar only applies to your ability to submit a new enrollment application to the Medicare program. In order to re-enroll, you must meet all requirements for your provider or supplier type.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name]
[Title]
[Company]

C. Revocation Letter Examples

Note that each example contains instructions to send appeals to both CMS and the contractor, regardless of the example reason, so that the contractors may include the appropriate appeal address based on the provider or supplier type that has been revoked. In addition, note that the section advising the provider/supplier of their right to submit a CAP are only included in the examples of revocations based on 42 C.F.R. § 424.535(a)(1).

1. Abuse of Billing Revocation Letter Example

[month] [day], [year]

[Entity name]
[Address]
[City, State & ZIP Code]

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

Dear [Provider/Supplier Name]:

Your Medicare privileges are being revoked effective June 16, 2012 for the following reasons:

Revocation reason: 42 CFR § 424.535(a)(8)

Specifically, you submitted 186 claims to Medicare for services provided after the date of death of 15 beneficiaries.

Right to Submit a Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. (Optional Coversheet sentence [To facilitate the processing of your reconsideration request, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.])

Reconsideration requests must--

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.

    - If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
    - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.
    - Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her behalf.

Providers and suppliers may--

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.
- Include an email address if you want to receive correspondence regarding your appeal via email.
- (If revoked under 42 C.F.R. § 424.535(a)(2)) Please note that you may not appeal through this process the merits of any exclusion by another Federal agency. Any further permissible administrative appeal involving the merits of such exclusion must be filed with the Federal agency that took the action.

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

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

[Name of MAC]
[Address]
[City], [ST] [Zip]

or

Centers for Medicare & Medicaid Services
Center for Program Integrity
Provider Enrollment & Oversight Group
Attn: Division of Provider Enrollment Appeals
7500 Security Boulevard
Mailstop AR-19-51
Baltimore, MD 21244-1850

Or emailed to:

[Insert MAC email address] or [ProviderEnrollmentAppeals@cms.hhs.gov]

Pursuant to 42 CFR §424.535(c), CMS is establishing a re-enrollment bar for a period of [Insert amount of time] that shall begin 30 days after the postmark date of this letter. This re-enrollment bar only applies to your ability to submit a new enrollment application to the Medicare program. In order to re-enroll, you must meet all requirements for your provider or supplier type.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name]
[Title]
[Company]

2. DMEPOS Supplier Revocation Letter Example

[month] [day], [year]

[Entity name]
[Address]
[City], [ST] [Zip]

Reference #: [PTAN #, Enrollment #, Case #, etc.]
NPI: [xxxxxxxxxx]

Dear [Supplier Name]:

The purpose of this letter is to inform you that pursuant to 42 C.F.R. § 405.800, 42 C.F.R. §424.57(e), and 42 C.F.R. § 424.535(a)(5), your Medicare supplier number [xxxxxxxxxx] for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) issued by *[Contractor name)* is revoked. The effective date of this revocation has been made retroactive to April 26, 2012, which is the date the Centers for Medicare & Medicaid Services (CMS) determined that your practice location is not operational.

We have determined that you are not in compliance with the supplier standards noted below:

42 C.F.R. § 424.57(c)(7) Maintain a physical facility on an appropriate site, accessible to the public and staffed during posted hours of business with visible signage.

Recently a representative of *[Contractor name]* attempted to conduct a visit of your facility on April 26, 2012. However, the visit was unsuccessful because your facility was closed, locked, and vacant. There was a "For Rent" sign on the window along with a sign directing customers to a nearby Rite Aid Pharmacy. Because we could not complete an inspection of your facility, we could not verify your compliance with the supplier standards. Based on a review of the facts, we have determined that your facility is not operational to furnish Medicare covered items and services. Thus, you are in violation of 42 CFR § 424.535(a)(5).

42 C.F.R. § 424.57(c)(26) must meet the surety bond requirements specified in 42 C.F.R. § 424.57(d).

We received a cancellation notice from Cook, Books & Hyde Surety indicating that the surety bond on file with the *billing* number 99999999 has been cancelled effective January 19, 2012. You failed to maintain a valid surety bond as required by law.

Section 1834 (j) of the Social Security Act states that, with the exception of medical equipment and supplies furnished incident to a physician's service, no payment may be made by Medicare for items furnished by a supplier unless the supplier has a valid Medicare billing number. Therefore, any expenses for items you supply to a Medicare beneficiary on or after the effective date of the revocation of your billing numbers are your responsibility and not the beneficiary's, unless you have proof that you have notified the beneficiary in accordance with section 1834(a)(18)(ii) of the Social Security Act and the beneficiary has agreed to take financial responsibility if the items you supply are not covered by Medicare. You will be required to refund on a timely basis to the beneficiary (and will be liable to the beneficiary for) any amounts collected from the beneficiary for such items. If you fail to refund the beneficiary as required under sections 1834(j)(4) and 1879(h) of the Social Security Act, you may be liable for Civil Monetary penalties.

(Delete the following paragraph if no re-enrollment bar established.)[Pursuant to 42 C.F.R. § 424.535(c), CMS is establishing a re-enrollment bar for a period of [Insert amount of time] that shall begin 30 days after the postmark date of this letter. This re-enrollment bar only applies to your ability to submit a new enrollment application to the Medicare program. In order to re-enroll, you must meet all requirements for your provider or supplier type.]

In addition, if submitting a *Form* CMS-855S application after the re-enrollment bar has expired, 42 C.F.R. § 424.57(d)(3)(ii) states suppliers will be required to maintain an elevated surety bond amount of $50,000 for each final adverse action imposed. Therefore, if you do not request a reconsideration of this decision or receive an unfavorable decision through the administrative review process, you must submit an elevated surety bond. Please note this amount is in addition to, and not in lieu of, the base $50,000 amount that must be maintained.

Right to Submit a Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the implementation of the initial determination. (Optional Coversheet sentence [To facilitate the processing of your reconsideration request, please utilize and include the attached coversheet [also found at [[insert web address for coversheet]] with your submission.])

Reconsideration requests must--

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
    - If the authorized representative is an attorney, the attorney's statement that he/she/they have the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
    - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.
    - Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the

provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her/their behalf.

Providers and suppliers may--

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.
- Include an email address if you want to receive correspondence regarding your appeal via email.

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

[*Contractor name*]
[Address]
[City], [ST] [Zip]

If you choose not to request a reconsideration of this decision, or you do not receive a favorable decision through the administrative review process, you must wait [insert number] years before resubmitting your CMS-855S application, per the re-enrollment bar cited above. Applications received by *[Contractor name]* prior to this timeframe will be returned.

If you have any questions, please contact our office at [*Contractor* call center phone number] between the hours of [x:00 AM/PM ET/CT/PT/MT] and [x:00 AM/PM ET/CT/PT/MT].

Sincerely,

[Name]
[Title]
[Company]

3. MDPP Supplier Use of an Ineligible Coach Revocation Letter Example

[month] [day], [year]

[Entity name]
[Address]
[City, State & ZIP Code]

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

Dear [MDPP Supplier Name]:

Your Medicare privileges are being revoked effective June 16, 2018 for the following reasons:

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

Per 42 CFR §424.205(d)(3), MDPP suppliers must only use eligible coaches.

Revocation reason: 42 CFR §424.205(h)(v) – Use of an Ineligible coach

Specifically, you were notified on April 1, 2018 that John Doe was ineligible to serve as an MDPP coach due to an assault conviction in June 2015. On April 15, 2018, you submitted a corrective action plan (CAP), which removed John Doe from Section 7 of your Form CMS-20134. On June 1, 2018, you submitted a claim with the NPI of John Doe for services rendered May 1st, after he was removed from your coach roster. This indicates knowingly use of an ineligible MDPP coach.

Revocations under 42 CFR §424.205(h)(v) are not eligible for CAP submission. The revocation becomes effective 30 days after the date of this notice.

Right to Submit a Corrective Action Plan (CAP) and Reconsideration Request:

Corrective Action Plan: (Only if revoked under 42 C.F.R. § 424.535(a)(1))

You may submit a corrective action plan (CAP) in response to the revocation of Medicare billing privileges under 42 C.F.R. § 424.535(a)(1). You may also request a reconsideration (described below). If your Medicare billing privileges were revoked under authorities other than 42 C.F.R. § 424.535(a)(1), you may **only** submit a reconsideration request in response to those revocation bases.

The CAP is an opportunity to demonstrate that you have corrected the deficiencies identified above and thereby, establish your eligibility to maintain enrollment in the Medicare program. (Optional Coversheet sentence [To facilitate the processing of your CAP, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.]) The CAP must--

- Be received in writing within 35 calendar days of the date of this letter and mailed or emailed to the address below;
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
    - If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
    - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.
    - Authorized or delegated officials for groups cannot sign and submit a CAP on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her behalf.
- Provide evidence to demonstrate that you are in compliance with Medicare requirements.

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

[Name of MAC] [Address] [City], [ST] [Zip]	or	Centers for Medicare & Medicaid Services Center for Program Integrity Provider Enrollment & Oversight Group Attn: Division of Provider Enrollment Appeals 7500 Security Boulevard Mailstop AR-19-51 Baltimore, MD 21244-1850

Or emailed to:

[Insert MAC email address] or [ProviderEnrollmentAppeals@cms.hhs.gov]

Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. (Optional Coversheet sentence [To facilitate the processing of your reconsideration request, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.])

Reconsideration requests must--

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
    - If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
    - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.
    - Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her behalf.

Providers and suppliers may--

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.
- Include an email address if you want to receive correspondence regarding your appeal via email.

- (If revoked under 42 C.F.R. § 424.535(a)(2)) Please note that you may not appeal through this process the merits of any exclusion by another Federal agency. Any further permissible administrative appeal involving the merits of such exclusion must be filed with the Federal agency that took the action.

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

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

[Name of MAC]
[Address]
[City], [ST] [Zip]

or

Centers for Medicare & Medicaid Services
Center for Program Integrity
Provider Enrollment & Oversight Group
Attn: Division of Provider Enrollment Appeals
7500 Security Boulevard
Mailstop AR-19-51
Baltimore, MD 21244-1850

Or emailed to:

[Insert MAC email address] or [ProviderEnrollmentAppeals@cms.hhs.gov]

Pursuant to 42 CFR §424.535(c), CMS is establishing a re-enrollment bar for a period of [Insert amount of time] that shall begin 30 days after the postmark date of this letter. This re-enrollment bar only applies to your ability to submit a new enrollment application to the Medicare program. In order to re-enroll, you must meet all requirements for your provider or supplier type.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name]
[Title]
[Company]

10.7.12 – Deactivation Model Letter

(Rev. 11859; Issued: 02-16-23; Effective: 03-17-23; Implementation: 03-17-23)

(To be sent by hard-copy mail, and via email if email address is listed in the provider/supplier correspondence mailing address on the enrollment record. Optional to send via fax if a valid fax number is available.)

[Month] [DD], [YYYY]

[Provider/Supplier Name] (as it appears in PECOS)
[Address]
[City], [State] [Zip Code]

Re: Deactivation of Medicare billing privileges
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)

NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (Internal Tracking)

Dear [Provider/Supplier Name]:

Your Medicare billing privileges are being deactivated effective [Month] [DD], [YYYY] pursuant to:

DEACTIVATION REASON:

- 42 C.F.R. § 424.540(a)[1-8]

[Specific reason for the deactivation of the provider/supplier's Medicare billing privileges.]

(If the deactivation is under 424.540(a)(1), an example narrative may include:

[Contractor Name] has reviewed your Medicare billing data and found that you have not submitted any claims since January 1, 2017, which is more than twelve calendar months from the date of this letter.)

(If the deactivation is under 424.540(a)(2), an example narrative may include:

[Contractor Name] has been informed that John Smith is deceased as of January 1, 2017. Your Medicare enrollment application, signed and certified on November 1, 2016, identifies John Smith as a 5% or greater owner. [Contractor Name] has not received a Medicare enrollment application reporting this change in ownership.)

REBUTTAL RIGHTS:

If you believe that this determination is not correct, you may rebut the deactivation as indicated in 42 C.F.R. § 424.545(b). The rebuttal must be received by this office in writing within *15* calendar days of the date of this letter. The rebuttal must state the issues or findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the rebuttal that you believe may have a bearing on the decision. You must submit all information that you would like to be considered in conjunction with the rebuttal. This includes any application(s) to update your enrollment, if necessary. You may only submit one rebuttal in response to this deactivation of your Medicare enrollment.

The rebuttal must be signed and dated by the individual provider/supplier, the authorized or delegated official, or a legal representative. (Delete next sentence if letter is related to a DMEPOS supplier's enrollment.) [Please be advised that authorized or delegated officials for groups cannot sign and submit a rebuttal on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her/their behalf.]

If the provider/supplier wishes to appoint a legal representative that is not an attorney to sign the rebuttal, the provider/supplier must include with the rebuttal a written notice authorizing the legal representative to act on the provider/supplier's behalf. The notice should be signed by the provider/supplier.

If the provider/supplier has an attorney sign the rebuttal, the rebuttal must include a statement from the attorney that he/she/they have the authority to represent the provider/supplier.

If you wish to receive communication regarding your rebuttal via email, please include a valid email address in your rebuttal submission.

The rebuttal should be sent to the following:
[Contractor Rebuttal Receipt Address]
[Contractor Rebuttal Receipt Email Address]
[Contractor Rebuttal Receipt Fax Number]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM ET/CT/MT/PT] and [x:00 AM/PM ET/CT/MT/PT].

Sincerely,

[Name] [Title] [Company]

10.7.15 –Revalidation Notification Letters

(Rev. 11859; Issued: 02-16-23; Effective: 03-17-23; Implementation: 03-17-23)

A. Revalidation Letter ***– Non-DMEPOS Supplier***

REVALIDATION

[month] [day], [year]

[Provider/Supplier Name]
[Address]
[City], [State] [Zip Code]

Dear [Provider/Supplier Name],

Every five years, CMS requires you to revalidate your Medicare enrollment record. You need to update or confirm all the information in your record, including your practice locations and reassignments.

We need this from you by **[Due date, as Month dd yyyy]**. If we don't receive your response by then, we may stop your Medicare billing privileges.

If you are a non-certified provider or supplier, and your enrollment is deactivated, you will maintain your original PTAN, however will not be paid for services rendered during the period of deactivation. This will cause a gap in your reimbursement.

What record needs revalidating by [Due date, as Month dd yyyy]

[Name] | **NPI** [NPI] | **PTAN** [PTAN]
Reassignments: <Only include this title if the record has any reassignments>
[Legal Business Name] | [dba Name] | Tax ID [Tax ID, mask all but last 4 digits]
<Repeat for other reassignments>

CMS lists the records that need revalidating at go.cms.gov/MedicareRevalidation.

What you need to do

Revalidate your Medicare enrollment record, through https://pecos.cms.hhs.gov/pecos/login.do or [form CMS-855 or Form CMS-20134].

- **Online:** PECOS is the fastest option. If you don't know your username or password, PECOS offers ways to retrieve them. Our customer service can also help you by phone at 866-484-8049.
- **Paper:** Download the right version of form [CMS-855 or Form CMS-20134] for your situation at cms.gov. We recommend getting proof of receipt for your mailing. Mail to [contractor address].

If you have a fee due, use PECOS to pay. If you feel you qualify for a hardship waiver, mail us a request on practice letterhead with financial statements, application form, and certification. For more on fees and exceptions, search cms.gov for "CR 7350" or "Fee Matrix".

A new Electronic Funds Transfer (EFT) Authorization Form (CMS-588) is only required to be submitted as part of your revalidation package if: (1) you have no Form CMS-588 on file with Medicare at all; or (2) you are changing any of your existing Form CMS-588 data. The current version of the form can be found at http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS588.pdf.

If you need help

Visit go.cms.gov/MedicareRevalidation
Call [contractor phone #] or visit [contractorsite.com] for more options.

Sincerely,
[Name]
[Title]
[Company]

B. Revalidation Letter – DMEPOS Supplier

REVALIDATION

[month] [day], [year]
[Provider/Supplier Name]
[Address]
[City], [State] [Zip Code]

Dear [Provider/Supplier Name],

Every three years, CMS requires you to revalidate your Medicare enrollment record. You need to update or confirm all the information in your record, including your practice location.

We need this from you by [Due date, as Month dd yyyy]. If we do not receive your response by then, we may stop your Medicare billing privileges.

If you are a non-certified provider or supplier and your enrollment is deactivated, you will maintain your original PTAN. However, you will not be paid for services rendered during the period of deactivation. This will cause a gap in your reimbursement.

What record needs revalidating by [Due date, as Month dd yyyy]
[Name] | NPI [NPI] | PTAN [PTAN]

[Legal Business Name] | [dba Name] | Tax ID [Tax ID, mask all but last 4 digits]

The CMS lists the records that need revalidating at go.cms.gov/MedicareRevalidation.

What you need to do

Revalidate your Medicare enrollment record, through https://pecos.cms.hhs.gov/pecos/login.do or [Form CMS-855S ~~or Form CMS-20134~~].

- ***Online:*** *PECOS is the fastest option. If you do not know your username or password, PECOS offers ways to retrieve them. Our customer service can also help you by phone at 866-484-8049.*

- ***Paper:*** *Download the right version of form [CMS-855S] for your situation at cms.gov. We recommend getting proof of receipt for your mailing. Mail to [contractor address].*

If you have a fee due, use PECOS to pay. If you feel you qualify for a hardship waiver, mail us a request on practice letterhead with financial statements, application form, and certification. For more on fees and exceptions, search cms.gov for "CR 7350" or "Fee Matrix".

A new Electronic Funds Transfer (EFT) Authorization Form (CMS-588) is only required to be submitted as part of your revalidation package if: (1) you have no Form CMS-588 on file with Medicare at all; or (2) you are changing any of your existing Form CMS-588 data.

The current version of the form can be found at http://www.cms.gov/Medicare/CMSForms/CMS-Forms/Downloads/CMS588.pdf.

If you need help

Visit go.cms.gov/MedicareRevalidation
Call [contractor phone #] or visit [contractorsite.com] for more options.

Sincerely,
[Name]
[Title]
[Company]

C. **Revalidation Letter – CHOW Scenario Only**

[month] [day], [year]

PROVIDER/SUPPLIER NAME
ADDRESS 1, ADDRESS 2
CITY STATE ZIP CODE

NPI:
PTAN:

Dear Provider/Supplier Name:

THIS IS A PROSPECTIVE PROVIDER ENROLLMENT REVALIDATION REQUEST

IMMEDIATELY SUBMIT AN UPDATED
PROVIDER ENROLLMENT PAPER APPLICATION 855 FORM TO VALIDATE YOUR ENROLLMENT INFORMATION

In accordance with Section 6401 (a) of the Patient Protection and Affordable Care Act, all new and existing providers must be reevaluated under the new screening guidelines. Medicare requires all enrolled providers and suppliers to revalidate their enrollment information every five years (reference 42 CFR §424.515). To ensure compliance with these requirements, existing regulations at 42 CFR §424.515(d) provide that the Centers for Medicare & Medicaid Services (CMS) is permitted to conduct off-cycle revalidations for certain program integrity purposes. Upon the CMS request to revalidate its enrollment, the provider/supplier has 60 days from the post mark date of this letter to submit complete enrollment information.

You previously submitted a change of ownership (CHOW) application that is currently being reviewed by the State Agency. Since your application has not been finalized, please validate that we have the most current information on file. Any updated information received since your initial submission will be forwarded to the State Agency for their final determination.

Providers and suppliers can validate their provider enrollment information using the paper application form. To validate by paper, download the appropriate and current CMS-855 Medicare Enrollment application from the CMS Web site at https://www.cms.gov/MedicareProviderSupEnroll/. Mail your completed application and all required supporting documentation to the [insert contractor name], at the address below.

[Insert application return address]

A new Electronic Funds Transfer (EFT) Authorization Form (CMS-588) is only required to be submitted as part of your revalidation package if (1) you have no Form CMS-588 on file with Medicare at all; or (2) you are changing any of your existing Form CMS-588 data. The current version of the form can be found at http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS588.pdf.

If additional time is required to complete the validation applications, you may request one 60-day extension, which will be added onto the initial 60 days given to respond to the request. The request may be submitted in writing from the individual provider, the Authorized or Delegated Official of the organization or the contact person and addressed to the MAC(s). The request should include justification of why a 60-day extension is needed. The request may also be made by contacting your MAC(s), via phone.

Physicians, non-physician practitioners and physician and non-physician practitioner organizations must report a change of ownership, any adverse legal action, or a change of practice location to the MAC within 30 days. All other changes must be reported within 90 days. For most but not all other providers and suppliers, changes of ownership or control, including changes in authorized official(s) must be reported within 30 days; all other changes to enrollment information must be made within 90 days.

Failure to submit complete enrollment application(s) and all supporting documentation within 60 calendar days of the postmark date of this letter may result in your Medicare billing privileges being deactivated and your CHOW not being processed. We strongly recommend you mail your documents using a method that allows for proof of receipt.

If you have any questions regarding this letter, please call [contractor telephone number will be inserted here] between the hours of [contractor telephone hours will be inserted here] or visit our Web site at [insert Web site] for additional information regarding the enrollment process or the [insert application type].

Sincerely,
[Your Name]
[Title]

D. Large Group Revalidation Notification Letter

[month] [day], [year]

PROVIDER/SUPPLIER GROUP NAME
ADDRESS 1, ADDRESS 2
CITY STATE ZIP CODE

NPI:
PTAN:

Dear Provider/Supplier Group Name:

THIS IS **NOT** A PROVIDER ENROLLMENT REVALIDATION REQUEST

This is to inform you that a number of physicians and/or non-physician practitioners reassigning all or some of their benefits to your group have been selected for revalidation. For your convenience, a list of those individuals is attached. A revalidation notice will be sent to the physician or non-physician practitioner within the next seven months. They will need to respond by the revalidation due date provided for each provider. It is the responsibility of the physician and/or non-physician practitioner to revalidate all their Medicare enrollment information and not just that associated with the reassignment to your group practice.

In accordance with Section 6401 (a) of the Patient Protection and Affordable Care Act, all new and existing providers must be reevaluated under the new screening guidelines. Medicare requires all enrolled providers and suppliers to revalidate their enrollment information every five years (reference 42 CFR §424.515). To ensure compliance with these requirements, existing regulations at 42 CFR §424.515(d) provide that the Centers for Medicare & Medicaid Services (CMS) is permitted to conduct off-cycle revalidations for certain program integrity purposes.

Physicians and non-physician practitioners can revalidate by using either Internet-based PECOS or submitting a paper CMS-855 enrollment application. Failure to submit a complete revalidation application and all supporting documentation within 60 calendar days may result in the physician or non-physician practitioner's Medicare billing privileges being deactivated. As such, your group will no longer be reimbursed for services rendered by the physician or non-physician practitioner.

If you have any questions regarding this letter, please call [contractor telephone number will be inserted here] between the hours of [contractor telephone hours will be inserted here] or visit our Web site at [insert Web site] for additional information regarding the revalidation process.

Sincerely,

[Your Name]
[Title]

E. Revalidation Pend Letter

PAYMENT HOLD

[month] [day], [year]

[Provider/Supplier Name]
[Address]
[City], [State] [Zip Code]

Dear [Provider/Supplier Name],

We are holding all payments on your Medicare claims, because you haven't revalidated your enrollment record with us. This does not affect your Medicare participation agreement, or any of its conditions.

Every [three or five years], CMS requires you to revalidate your Medicare enrollment record information. You need to update or confirm all the information in your record, including your practice locations and reassignments.

Failure to respond to this notice will result in a possible deactivation of your Medicare enrollment. If you are a non-certified provider or supplier, and your enrollment is deactivated, you will maintain your original PTAN, however will not be paid for services rendered during the period of deactivation. This will cause a gap in your reimbursement.

What record needs revalidating

[Name] | **NPI** [NPI] | **PTAN** [PTAN]
Reassignments:
[Legal Business Name] | [dba Name] | Tax ID [Tax ID, mask all but last 4 digits]
<Repeat for other reassignments>

CMS lists the records that need revalidating at **go.cms.gov/MedicareRevalidation**.

How to resume your payments

Revalidate your Medicare enrollment record, through https://pecos.cms.hhs.gov/pecos/login.do or [form CMS-855 or Form CMS-20134].

- **Online:** PECOS is the fastest option. If you don't know your username or password, PECOS offers ways to retrieve them. Our customer service can also help you by phone at 866-484-8049.
- **Paper:** Download the right version of [form CMS-855 or Form CMS-20134] for your situation at cms.gov. We recommend getting proof of receipt for your mailing. Mail to [contractor address].

If you have a fee due, use PECOS to pay. If you feel you qualify for a hardship waiver, mail us a request on practice letterhead with financial statements, application form, and certification.

If you need help

Visit **go.cms.gov/MedicareRevalidation**
Call [contractor phone #] or visit [contractorsite.com] for more options.

Sincerely,
[Name]
[Title]
[Company]

F. Revalidation Deactivation Letter

STOPPING BILLING PRIVILEGES

[month] [day], [year]

[Provider/Supplier Name]
[Address]
[City], [State] [Zip Code]

Dear [Provider/Supplier Name],

Your Medicare billing privileges are being deactivated effective [Month] [DD], [YYYY], pursuant to 42 C.F.R. § 424.540(a)(3) because you have not timely revalidated your enrollment record with us, or your revalidation application has been rejected because you did not timely respond to our requests for more information. We will not pay any claims after this date.

Every five years [three for *DMEPOS suppliers*], CMS requires you to revalidate your Medicare enrollment record.

What record needs revalidating

[Name] | **NPI** [NPI] | **PTAN** [PTAN]
Reassignments:
[Legal Business Name] | [dba Name] | Tax ID [Tax ID, mask all but last 4 digits]
<Repeat for other reassignments>

CMS lists the records that need revalidating at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Revalidations.html.

Rebuttal Rights:

If you believe that this determination is not correct, you may rebut the deactivation as indicated in 42 C.F.R. § 424.546. The rebuttal must be received in writing within 15 calendar days of the date of this letter. The rebuttal must state the issues or findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the rebuttal that you believe may have a bearing on the decision. You must submit all information that you would like to be considered in conjunction with the rebuttal. This includes any application(s) to update your enrollment, if necessary. You may only submit one rebuttal in response to this deactivation of your Medicare enrollment.

The rebuttal must be signed and dated by the individual provider/supplier, the authorized or delegated official, or a legal representative. *(Delete next sentence if letter is related to a*

DMEPOS supplier's enrollment.) Authorized or delegated officials for groups cannot sign and submit a rebuttal on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her/their behalf.

If the provider/supplier wishes to appoint a legal representative that is not an attorney to sign the rebuttal, the provider/supplier must include with the rebuttal a written notice authorizing the legal representative to act on the provider*'s or* supplier's behalf. The notice should be signed by the provider/supplier.

If the provider/supplier has an attorney sign the rebuttal, the rebuttal must include a statement from the attorney that he/she has the authority to represent the provider/supplier.

If you wish to receive communication regarding your rebuttal via email, please include a valid email address in your rebuttal request.

The rebuttal should be sent to the following:

[Contractor Rebuttal Receipt Address]
[Contractor Rebuttal Receipt Email Address]
[Contractor Rebuttal Receipt Fax Number]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 a.m./p.m ET/MT/CT/PT] and [x:00 a.m./p.m ET/MT/CT/PT].

How to recover your billing privileges

Revalidate your Medicare enrollment record, through PECOS.cms.hhs.gov, or [Form CMS-855 or Form CMS-20134].

- Online: PECOS is the fastest option. If you don't know your username or password, PECOS offers ways to retrieve them. Our customer service can also help you by phone at 866-484-8049.

- Paper: Download the right version of [form CMS-855 or Form CMS-20134] for your situation at cms.gov. We recommend getting proof of receipt for your mailing. Mail to [contractor address].

If you have a fee due, use PECOS to pay. If you feel you deserve a hardship waiver, mail us a request on practice letterhead with financial statements, application form, and certification.

If you are a non-certified provider or supplier, and your enrollment is deactivated, you will maintain your original PTAN, however will not be paid for services rendered during the period of deactivation. This will cause a gap in your reimbursement.

If you need help Visit https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Revalidations.html.

Call [contractor telephone number] or visit [contractorsite.com] for more options.

Sincerely,

[Name]
[Title]
[Company]

G. Revalidation Past-Due Group Member Letter

REVALIDATION | Past-Due Group Member

[month] [day], [year]

[Provider/Supplier Name]
[Address]
[City], [State] [Zip Code]

Dear [Provider/Supplier Name],

Every five years, CMS requires providers to revalidate their Medicare enrollment records. You have not revalidated by the requested due date of [revalidation due date].

You need to update or confirm all the information in your record, including your practice locations and reassignments. If you are a non-certified provider or supplier, and your enrollment is deactivated, you will maintain your original PTAN, however will not be paid for services rendered during the period of deactivation. This will cause a gap in your reimbursement.

If multiple records below need to be revalidated, please coordinate with the appropriate parties to provide only one response.

What record needs revalidating

[Name] | **NPI** [NPI] | **PTAN** [PTAN]
Reassignments: <Only include this title if the record has any reassignments>
[Legal Business Name] | [dba Name] | Tax ID [Tax ID, mask all but last 4 digits]
<Repeat for other reassignments>

CMS lists the records that need revalidating at **go.cms.gov/MedicareRevalidation**.

What your group member needs to do

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

- **Online:** PECOS is the fastest option. If they don't know their username or password, PECOS offers ways to retrieve them. Our customer service can also help by phone at 866-484-8049.
- **Paper:** Download the right version of [form CMS-855 or Form CMS-20134] for their situation at cms.gov. We recommend getting proof of receipt for this mailing. Mail to [contractor address].

If your group member needs help

Visit **go.cms.gov/MedicareRevalidation**
Call [contractor phone #] or visit [contractorsite.com] for more options.

Sincerely,
[Name]
[Title]
[Company]

H. Model Return Revalidation Letter

RETURN REVALIDATION

[month] [day], [year]

[Provider/Supplier Name]
[Address]
[City], [State] [Zip Code]

NPI: [xxxxxxxxxx]

Dear [Provider/Supplier Name],

Your Medicare enrollment application(s) was received on [date]. We are closing this request and returning your application(s) for the following reason(s):

- The [Form CMS-855 or Form CMS-20134] application received by [PROVIDER/SUPPLIER NAME] was unsolicited.
    - An unsolicited revalidation is one that is received more than seven months prior to the provider/supplier's due date. Due dates are established around 5 years from the provider/suppliers last successful revalidation or their initial enrollment.
    - To find the provider/suppliers revalidation due date, please go to http://go.cms.gov/MedicareRevalidation.
    - If you are not due for revalidation in the current seven-month period, you will find that your due date is listed as "TBD" (or To Be Determined). This means that you do not yet have a due date for revalidation within the current seven-month period. This list with be updated monthly.

- If your intention is to change information on your Medicare enrollment file, you must complete a new Medicare enrollment application(s) and mark 'change' in section 1 of the [form CMS-855 or Form CMS-20134].

- Please address the above issues as well as sign and date the new certification statement page on your resubmitted application(s).

Providers and suppliers can apply to enroll in the Medicare program using one of the following two methods:

1. Internet-based Provider Enrollment, Chain and Organization System (PECOS). Go to: https://pecos.cms.hhs.gov/pecos/login.do.

2. Paper application process: Download and complete the Medicare enrollment application(s) at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/EnrollmentApplications.html.

If you need help

Visit http://go.cms.gov/MedicareRevalidation, or
Call2 [contractor phone #] or visit [contractorsite.com] for more options.

Sincerely,
[Name]
[Title]
[Company]