CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 609	**Date: August 14, 2015**
	Change Request 9174

Transmittal 605, dated July 31, 2015, is being rescinded and replaced by Transmittal 609 to incorporate information from CR 9139, Transmittal 592 erroneously omitted in section 15.27.2. All other information remains the same.

SUBJECT: Clarification Regarding the Processing of Certain Provider Enrollment-Related Transactions

I. SUMMARY OF CHANGES: This change request (CR) makes several minor revisions to chapter 15 of Pub. 100-08. These changes include, but are not limited to-- (1) Revising the process for reviewing "40 percent certifications" submitted by community mental health centers; (2) Clarifying the instances in which prior Centers for Medicare & Medicaid Services (CMS) approval of a provider enrollment denial or revocation is necessary; and (3) Providing information regarding the processing of reassignment packages and the submission of appeals.

EFFECTIVE DATE: November 2, 2015
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: November 2, 2015
Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	15/Table of Contents
R	15/4.1.1.1 - CMHC 40 Percent Rule
R	15/5.2.1 - Licenses and Certifications
R	15/5.3 - Final Adverse Actions
R	15/5.17 - Supporting Documents
R	15/7.6 - Special Processing Guidelines for Form CMS-855A, Form CMS-855B, Form CMS-855I and Form CMS-855R Applications
R	15/7.7.5 - Sole Proprietorships
R	15/8.4 - Denials

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	15/20.1 - Site Verifications
R	15/24.7.1 - Model Approval Letter
R	15/24.8.1 - Model Denial Letter
R	15/24.8.2 - Denial Example #1 – Discipline Not Eligible
R	15/24.8.3 - Denial Example #2 – Criteria for Eligible Discipline Not Met
R	15/24.8.4 - Denial Example #3 – Provider Standards Not Met
R	15/24.8.5 - Denial Example #4 – Business Type Not Met
R	15/24.8.6 - Denial Example #5 – Existing or Delinquent Overpayments
R	15/24.9.1 - Model Revocation Letter for Part B Suppliers and Certified Providers and Suppliers
N	15/24.10.2 - Favorable Corrective Action Plan (CAP)/Reconsideration Decision – Denials
N	15/24.10.3 - Favorable Corrective Action Plan (CAP)/Reconsideration Decision – Revocations
N	15/24.10.4 - Unfavorable Corrective Action Plan (CAP)/Reconsideration Decision – Denials
N	15/24.10.5 - Unfavorable Corrective Action Plan (CAP)/Reconsideration Decision – Revocations
R	15/25.1.2 - Reconsideration Requests – Non-Certified Providers/Suppliers
R	15/25.2 - Appeals Involving Certified Providers and Certified Suppliers
R	15/25.2.2 - Reconsideration Requests – Certified Providers and Certified Suppliers
R	15/27.2 - Revocations
R	15/28 - Deceased Practitioners

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: 609	Date: August 14, 2015	Change Request: 9174

Transmittal 605, dated July 31, 2015, is being rescinded and replaced by Transmittal 609 to incorporate information from CR 9139, Transmittal 592 erroneously omitted in section 15.27.2. All other information remains the same.

SUBJECT: Clarification Regarding the Processing of Certain Provider Enrollment-Related Transactions

EFFECTIVE DATE: November 2, 2015
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: November 2, 2015

I. GENERAL INFORMATION

A. Background: Chapter 15 of Pub. 100-08 contains instructions regarding-- (1) The processing of Form CMS-855 applications, and (2) Other provider enrollment-related issues. This CR makes several minor revisions to this chapter. The principal purpose of this CR is to help streamline the processing of certain types of provider enrollment-related transactions.

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

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
9174.1	If the contractor receives a "40 percent certification" with a community mental health center's Form CMS-855 or timely receives the certification as part of a development request, the contractor shall review the certification to ensure that it complies with §485.918(b)(1) and the provisions of Pub. 100-08, chapter 15, section 15.4.1.1.1.	X								
9174.1.1	If the "40 percent certification" is compliant with §485.918(b)(1) and section 15.4.1.1.1, the contractor shall continue processing the application; if the certification is not compliant, the contractor shall deny the application or, if it chooses, develop for a revised certification.	X								
9174.2	For expired non-certified supplier licenses, the contractor		X							

Number	Requirement	Responsibility								
		A/B MAC			D M E M A C	Shared-System Maintainers				Other
		A	B	H H H		F I S S	M C S	V M S	C W F	
	shall enter the day after the expiration as the expiration date; for revoked and suspended non-certified supplier licenses, the contractor shall enter the revocation date (not the day after) as the expiration date.									
9174.3	In the circumstances described in Pub. 100-08, chapter 15, section 15.7.6, the contractor shall examine the incoming forms to see if a reassignment may be involved.		X							
9174.4	For cases involving §424.530(a)(4), the contractor shall obtain approval of both the denial and the denial letter from CMS Central Office's Provider Enrollment Unit via the MACRevocationRequests@cms.hhs.gov mailbox prior to sending the denial letter.	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 15 - Medicare Enrollment

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15.24.8.4 –Denial Example #3 – Provider *S*tandards *N*ot *M*et

15.24.8.5 –Denial Example #4 – Business *T*ype *N*ot *M*et

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15.4.1.1.1 – CMHC 40 Percent Rule

(Rev 609., Issued: 08-14-15, Effective: 11-02-15, Implementation: 11-02-15)

(The policies in this section 15.4.1.1.1 apply on and after October 29, 2014.)

A. Background

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

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

- The entity has reviewed the CMHC's client care data
- For:
  - Initial enrollments: The CMHC meets the 40 percent requirement for the prior 3 months.
  - Revalidations: The CMHC meets the 40 percent requirement for each of the intervening 12-month periods between initial enrollment and revalidation.

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

B. Processing

The contractor shall abide by the following:

1. The contractor does not receive the certification with the *Form* CMS-855 -- The contractor shall develop for the certification as it would with any other form of required supporting documentation. If the CMHC fails to submit the certification within the applicable time period, *the contractor shall follow the instructions in section 15.8.2 of this chapter.*

2. The contractor receives the certification with the *Form* CMS-855 or timely receives the certification as part of a development request -- *The contractor shall review the certification to ensure that it complies with § 485.918(b)(1) and the provisions of this section 15.4.1.1.1. If the certification is compliant, the contractor shall continue processing the application; if the certification is not compliant, the contractor shall deny the application or, if it chooses, develop for a revised certification.*

Sections (B)(1) and (2) above do not apply if the contractor determines that the *Form* CMS-855 can be returned under section 15.8.1 of this chapter.

If the *contractor* exceeds applicable timeliness standards due to the instructions in this section 15.4.1.1.1, the contractor shall accordingly document the provider file consistent with section 15.10 of this chapter.

C. Special Guidelines

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

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

3. The contractor shall include the certification in the recommendation package it sends to the *s*tate agency.

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

15.5.2.1 – Licenses and Certifications

(Rev 609., Issued: 08-14-15, Effective: 11-02-15, Implementation: 11-02-15)

The extent to which the applicant must complete the licensure or certification information in section 2 of the Form CMS-855 depends upon the provider type involved. For instance, some states may require a particular provider to be "certified" but not "licensed," or vice versa.

The provisions in this section 15.5.2.1 are subject to the "processing alternatives" described in sections 15.7.1.3.1 through 15.7.1.3.2 of this chapter.

A. Form CMS-855B and Form CMS-855I

The contractor shall verify that the supplier is licensed and/or certified to furnish services in:

- The state where the supplier is enrolling.

- Any other state within the contractor's jurisdiction in which the supplier (per section 4 of the Form CMS-855) will maintain a practice location.

The only licenses that must be submitted with the application are those required by Medicare or the state to function as the supplier type in question. Licenses and permits that are not of a medical nature are not required, though business licenses needed for the applicant to operate as a health care facility or practice must be submitted. In addition, there may be instances where the supplier is not required to be licensed at all in a particular state; the contractor shall still ensure, however, that the supplier meets all applicable state and Medicare requirements.

The contractor shall also adhere to the following:

- **State Surveys:** Documents that can only be obtained after state surveys or accreditation need not be included as part of the application. (This typically occurs with ASCs and portable x-ray suppliers.) The supplier must, however, furnish those documents that can be submitted prior to the survey/accreditation.

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

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

- **Notarization:** If the applicant submits a license that is not notarized or "certified true," the contractor shall verify the license with the appropriate state agency. (A notarized copy of an original document has a stamp that says "official seal," along with the name of the notary public, the state, the county, and the date the notary's commission expires. A certified "true copy" of an original document has a raised seal that identifies the state and county in which it originated or is stored.)

- **Temporary Licenses:** If the supplier submits a temporary license, the contractor shall note the expiration date in PECOS. Should the supplier fail to submit the permanent license after the temporary license expiration date, the contractor shall initiate revocation procedures. (A temporary permit – one in which the applicant is not yet fully licensed and must complete a specified number of hours of practice in order to obtain the license – is not acceptable.)

- **Revoked/Suspended Licenses:** If the applicant had a previously revoked or suspended license reinstated, the applicant must submit a copy of the reinstatement notice with the application.

- **Date of Enrollment –** For suppliers other than ASCs and portable x-rays, the date of enrollment is the date the contractor approved the application. The enrollment date cannot be made retroactive. To illustrate, suppose the supplier met all the requirements needed to enroll in Medicare (other than the submission of a Form CMS-855I) on January 1. He sends his Form CMS-855I to the contractor on May 1, and the contractor approves the application on June 1. The date of enrollment is June 1, not January 1. (**NOTE:** The matter of the date of enrollment is separate from the question of the date from which the supplier may bill.)

- ***License Expiration/Revocation Dates for Non-Certified Suppliers*** *– For expired licenses, the contractor shall enter into PECOS the day after the expiration as the expiration date. For revoked and suspended licenses, the contractor shall enter into PECOS the revocation date (not the day after) as the expiration date.*

See section 15.7.5.1 of this chapter for special instructions related to periodic license reviews and certain program integrity matters.

B. Form CMS-855A

Documents that can only be obtained after state surveys or accreditation need not be included as part of the application, nor must the data be provided in section 2 of the Form CMS-855A. The provider shall, however, furnish those documents that can be submitted prior to the survey/accreditation. The contractor shall include all submitted licenses, certifications, and accreditations in the enrollment package that is forwarded to the state and/or RO.

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

15.5.3 – Final Adverse Actions

(Rev 609., Issued: 08-14-15, Effective: 11-02-15, Implementation: 11-02-15)

Unless stated otherwise, the instructions in this section 15.5.3 apply to the following sections of the Form CMS-855:

- Section 3

- Section 4A of the CMS-855I

- Section 5
- Section 6

A. Disclosure of Final Adverse Action

If a final adverse action is disclosed on the Form CMS-855, the provider must furnish documentation concerning the type and date of the action, what court(s) and law enforcement authorities were involved, and how the adverse action was resolved. The documentation must be furnished regardless of whether the adverse action occurred in a state different from that in which the provider seeks enrollment or is enrolled.

In addition:

1. Reinstatements - If the person or entity in question was excluded or debarred but has since been reinstated, the contractor shall confirm the reinstatement through the OIG or, in the case of debarment, through the federal agency that took the action. It shall also ensure that the provider submits written proof of the reinstatement (e.g., reinstatement letter).

2. Revocation Reversals – Medicare revocations that were reversed on appeal need not be reported on the Form CMS-855.

3. Scope of Disclosure – All final adverse actions that occurred under the LBN and TIN of the disclosing entity (e.g., applicant; section 5 owner) must be reported. This includes Medicare revocations that: (1) were initiated by a different Medicare contractor in another contractor jurisdiction, and (2) involve a different provider or supplier type. Consider the following examples:

   Example (a) - Smith Pharmacy, Inc. had 22 separately enrolled locations in 2009. Each location was under Smith's LBN and TIN. In 2010, two locations were revoked, leaving 20 locations. Smith submits a Form CMS-855S application for a new location on Jones Street. The two revocations in 2010 must be reported on the Jones Street application. Suppose, however, that each of Smith's locations had its own LBN and TIN. The Jones Street application need not disclose the two revocations from 2010.

   Example (b) - An HHA, hospice*,* and hospital are enrolling under Corporation X's LBN and TIN. X is listed as the provider in section 2 of each applicant's Form CMS-855A. All three successfully enroll. Six months later, Company X's billing privileges for the HHA are revoked. Both the hospice and the hospital must report the revocation via a Form CMS-855A change request because the revocation occurred under the provider's LBN and TIN. Assume now that X seeks to enroll an ASC under X's LBN and TIN. The HHA revocation would have to be reported in section 3 of the ASC's initial Form CMS-855B.

   Example (c) – Company Y is listed as the provider/supplier for two HHAs and *two* suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS). These *four* providers/suppliers are under Y's LBN and TIN. Each provider/supplier is located in a different State. All are enrolled. Y's billing privileges for one of the DMEPOS suppliers are revoked. Y now seeks to enroll an ASC in a fifth State. Y must disclose the DMEPOS revocation on the ASC's initial Form CMS-855, even though the revocation: (1) was done by a Medicare contractor other than that with which the ASC seeks enrollment, and (2) occurred in a *s*tate different from that in which the ASC is located.

   Example (d) – Company Alpha is listed as an owner in section 5 of the Form CMS-855A. Alpha operates two health care providers – Y and Z - under its LBN and TIN. Y was subject to a General Services Administration debarment, which ended in 2009. The debarment would have to be reported in section 5, since it occurred under Z's LBN and TIN.

4. Timeframe – With the exception of the felony convictions identified in #1 under "Convictions" in section 3 of the Form CMS-855, all final adverse actions must be reported regardless of when they occurred.

5. Corporate Integrity Agreements (CIAs) – CIAs need not be disclosed on the Form CMS-855.

6. Evidence to Indicate Adverse Action – There may be instances where the provider *or supplier* states in section 3, 4A of the *Form* CMS-855I, 5, and/or 6 that the person or entity has never had a final adverse action imposed against him/her/it, but the contractor finds evidence to indicate otherwise. In such cases, the contractor shall contact its *CMS Provider Enrollment Business Function Lead (PEBFL)* for guidance.

B. Prior Approval

If a current exclusion or debarment is disclosed on the Form CMS-855, the contractor shall deny the application in accordance with the instructions in this chapter; prior approval from *CMS Central Office's provider enrollment unit (COPEU)* is *unnecessary.* If any other final adverse action is listed*,* the contractor shall refer the matter to its *PEBFL* for review. When referring the action to its *PEBFL* (which shall be done via e-mail or fax), the contractor shall include the following information: (1) provider/supplier name and *NPI*; (2) version of the Form CMS-855 involved; (3) reason for provider/supplier's submission of the application; (4) a summary of the adverse legal facts; and (5) whether the provider/supplier has previously disclosed this or any other final adverse action.

(If the contractor learns via any means other than the submission of a Form CMS-855 (e.g., from law enforcement, notice from another contractor) that an enrolled provider or supplier has had any final adverse action (regardless of type) imposed against it, the contractor shall refer the matter to its *PEBFL* for guidance.)

C. Review of PECOS

If the contractor denies an application or revokes a provider based on a final adverse action, the contactor shall search PECOS (or, if the provider is not in PECOS, the contractor's internal system) to determine:

- Whether the person/entity with the adverse action has any other associations (e.g., is listed in PECOS as an owner of three Medicare-enrolled providers), or

- If the denial/revocation resulted from an adverse action imposed against an owner, managing employee, director, etc., of the provider, whether the person/entity in question has any other associations (e.g., a managing employee of the provider is identified as an owner of two other Medicare-enrolled HHAs).

If such an association is found and, per 42 CFR § 424.535, there are grounds for revoking the billing privileges of the other provider, the contractor shall initiate revocation proceedings with respect to the latter.

If the "other provider" is enrolled with a different contractor, the contractor shall notify the latter - via fax or e-mail – of the situation, at which time the latter shall take the revocation action. To illustrate, suppose John Smith attempted to enroll with Contractor X as a physician. Smith is currently listed as an owner of Jones Group Practice, which is enrolled with Contractor Y. Contractor X discovers that Smith was recently convicted of a felony. X therefore denies Smith's application. X must also notify Y of the felony conviction; Y shall then revoke Jones' billing privileges per 42 CFR § 424.535(a)(3).

D. Chain Home Offices, Billing Agencies, and HHA Nursing Registries

If the contractor discovers that an entity listed in section 7, 8, or 12 of the Form CMS-855 has had a final adverse action imposed against it, the contractor shall contact its *PEBFL* for guidance.

E. System for Award Management (SAM)

When an entity or individual is listed as debarred in the SAM (formerly, the General Services Administration Excluded Parties List System), the SAM record may identify associated entities and persons that are also debarred. To illustrate, suppose John Smith is identified as debarred. The SAM record may also list individuals and entities associated with John Smith that are debarred as well, such as "John Smith Company," "Smith Consulting," "Jane Smith," and "Joe Smith."

If the contractor learns via the *Form* CMS-855 verification process, a Zone Program Integrity Contractor *(ZPIC)* referral, or other similar means that a particular person or entity is debarred, the contractor shall search the person/entity in the SAM to see if the SAM record discloses any associated parties that are debarred. If associated parties are listed, the contractor – after verifying, via the instructions in this chapter, that the associated party is indeed debarred – shall check PECOS to determine whether the party is listed in any capacity. If the party is listed, the contractor shall take all applicable steps outlined in this chapter with respect to revocation proceedings against the party and against any persons/entities with whom the party is associated. For instance, using our example above, if the contractor confirms that Jane Smith is debarred and PECOS shows Jane Smith as an owner of Entity X, the contractor shall, as applicable, initiate revocation proceedings against X.

15.5.17 – *Supporting Documents*

(Rev 609., Issued: 08-14-15, Effective: 11-02-15, Implementation: 11-02-15)

When documentation of the provider's or supplier's TIN and/or LBN is required, the contractor may accept a CP-575, a federal tax department ticket, or any other pre-printed document from the IRS that identifies the TIN and/or LBN.

15.7.6 - Special Processing Guidelines for Form CMS-855A, Form CMS-855B, Form CMS-855I and Form CMS-855R Applications

(Rev 609., Issued: 08-14-15, Effective: 11-02-15, Implementation: 11-02-15)

A. Reassignment Packages

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

1. Only the Form CMS-855Rs are submitted - If a brand new group with new practitioners is attempting to enroll but submits only the Form CMS-855Rs for its group members (i.e., neither the initial Form CMS-855B nor the initial Form CMS-855Is were submitted), the contractor shall develop for the other forms if they are not submitted within 15 calendar days after receipt of the Form CMS-855Rs.

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

3. Only the Form CMS-855B is submitted - If a brand new group wants to enroll but submits only the Form CMS-855B without including the Form CMS-855Is and Form CMS-855Rs for its group members (i.e., the Form CMS-855B arrives alone, without the other forms), the contractor shall develop for the other forms if they are not submitted within 15 calendar days after receipt of the Form CMS-855B.

4. Only the Form CMS-855I is submitted – Suppose an individual: (1) submits only the Form CMS-855I without including the Form CMS-855B and Form CMS-855R, and (2) indicates on the Form CMS-855I that he/she will be reassigning all or part of his/her benefits to the group practice. The contractor shall develop for the other forms if they are not submitted within 15 calendar days after receipt of the Form CMS-855I.

Suppose an individual: (1) submits only the Form CMS-855I, and (2) indicates on the Form CMS-855I that he/she will be reassigning all or part of his/her benefits to an existing Part A CAH II. The contractor shall develop for the CMS-855R if it is not submitted within 15 calendar days after receipt of the Form CMS-855I. Upon receipt of the CMS-855R, the contractor shall process the application and reassign the individual to the Part A entity.

B. Additional Instructions

The contractor shall abide by the following:

1. If an individual is joining a group that was enrolled prior to the Form CMS-855A or Form CMS-855B (i.e., the group or CAH II never completed a Form CMS-855), the contractor shall obtain a Form CMS-855A from the CAH II or Form CMS-855B from the group. During this timeframe, the contractor shall not withhold any payment from the group solely on the grounds that a Form CMS-855A or Form CMS-855B has not been completed. Once the group or CAH II's application is received, the contractor shall add the new reassignment; if the Form CMS-855R was not submitted, the contractor shall secure it from the provider or supplier.

2. If a provider or supplier is changing its TIN, the transaction shall be treated as a brand new enrollment as opposed to a change of information. Consequently, the provider or supplier must complete a full Form CMS-855 application and a new enrollment record must be created in PECOS. (This does not apply to ambulatory surgical centers and portable x-ray suppliers. These entities can submit a TIN change as a change of information unless a change of ownership is involved. If the latter is the case, the applicable instructions in sections 15.7.8.2.1 through 15.7.8.2.1.2 of this chapter should be followed.)

3. If the provider or supplier is adding or changing a practice location and the new location is in another State within the contractor's jurisdiction, the contractor shall ensure that the provider or supplier meets all the requirements necessary to practice in that State (e.g., licensure). A complete Form CMS-855 for the new State is not required, though the contractor shall create a new enrollment record in PECOS for the new State.

4. All members of a group practice must be entered into PECOS.

15.7.7.5 - Sole Proprietorships

(Rev 609., Issued: 08-14-15, Effective: 11-02-15, Implementation: 11-02-15)

If the provider indicates in section 2B1 of the Form CMS-855A that he/she is a sole proprietor, the contractor shall note the following:

- The LBN in section 2B1 should list the person's (the sole proprietor's) legal name.
- The TIN in section 2B1 should list the person's social security number.

- Section 3 of the Form CMS-855A must be completed with information about the individual's final adverse action history.

- Section 5 of the Form CMS-855A will not apply unless the person has hired an entity to exercise managerial control over the business (i.e., no owners will be listed in section 5, as the sole owner has already reported his/her personal information in sections 2 and 3).

- No owners, partners, or directors/officers need to be reported in section 6. However, all managing employees (whether W-2 or not) must be listed.

- The sole proprietor may list multiple authorized or delegated officials in sections 15 and 16.

Since most sole proprietorships that complete the Form CMS-855A will also have an employer identification number (EIN), the contractor shall request from the provider a copy of its CP-575*, any federal tax department tickets, or any other preprinted information from the IRS containing the provider's EIN.*

15.8.4 – Denials

(Rev 609., Issued: 08-14-15, Effective: 11-02-15, Implementation: 11-02-15)

A. Denial Reasons

When issuing a denial, the contractor shall insert the appropriate regulatory basis (e.g., 42 CFR § 424.530(a)(1)) into its *denial* letter. The contractor shall not use provisions from this chapter 15 as the basis for denial. *Except as described in section 15.8.4(B) below or as otherwise stated in this chapter, the contractor may issue a denial letter without prior approval from COPEU of the denial or the denial letter.*

If the applicant is a certified provider or certified supplier and one of the denial reasons listed below is implicated, the contractor need not submit a recommendation for denial to the *s*tate/RO. The contractor can simply: (1) deny the application, (2) close out the PECOS record, and (3) send a denial letter to the provider. The contractor shall copy the *s*tate and the RO on said letter.

Denial Reason 1 (42 CFR § 424.530(a)(1)) – Not in Compliance with Medicare Requirements

The provider or supplier is determined not to be in compliance with the enrollment requirements in subpart P (of Part 424) or on the enrollment application applicable to its provider or supplier type, and has not submitted a plan of corrective action as outlined in 42 CFR part 488. Such non-compliance includes, but is not limited to, the following situations:

a. The provider or supplier does not have a physical business address or mobile unit where services can be rendered.

b. The provider or supplier does not have a place where patient records are stored to determine the amounts due such provider or other person.

c. The provider or supplier is not appropriately licensed.

d. The provider or supplier is not authorized by the *f*ederal/*s*tate/local government to perform the services that it intends to render.

e. The provider or supplier does not meet CMS regulatory requirements for the specialty that it seeks to enroll as. (See section 15.4.8 of this chapter for examples of suppliers that are not eligible to participate.)

f. The provider or supplier does not have a valid social security number (SSN) or employer identification number (EIN) for itself, an owner, partner, managing organization/employee, officer, director, medical director, and/or authorized or delegated official.

g. The applicant does not qualify as a provider of services or a supplier of medical and health services. (For instance, the applicant is not recognized by any Federal statute as a Medicare provider or supplier (e.g., marriage counselors.)) An entity seeking Medicare payment must be able to receive reassigned benefits from physicians in accordance with the Medicare reassignment provisions in § 1842(b)(6) of the Act (42 U.S.C. 1395u(b)).

h. The provider or supplier does not otherwise meet general enrollment requirements.

With respect to (e) above – and, as applicable, (c) and (d) - the contractor's denial letter shall cite the appropriate statutory and/or regulatory citation(s) containing the specific licensure/certification/authorization requirement(s) for that provider or supplier type. For a listing of some of these statutes and regulations, refer to section 15.4 et seq. of this chapter.

NOTE: The contractor must identify in its denial letter the exact provision within said statute(s)/regulation(s) that the provider/supplier is not in compliance with.

Denial Reason 2 (42 CFR § 424.530(a)(2)) – Excluded/Debarred from Federal Program

The provider or supplier, or any owner, managing employee, authorized or delegated official, medical director, supervising physician, or other health care personnel of the provider or supplier who is required to be reported on the CMS-855 is—

- Excluded from Medicare, Medicaid, or any other Federal health care program, as defined in 42 CFR §1001.2, in accordance with section 1128, 1128A, 1156, 1842, 1862, 1867 or 1892 of the Social Security Act, or

- Debarred, suspended, or otherwise excluded from participating in any other Federal procurement or non-procurement program or activity in accordance with section 2455 of the Federal Acquisition Streamlining Act.

Denial Reason 3 (42 CFR § 424.530(a)(3)) – Felony Conviction

The provider, supplier, or any owner or managing employee of the provider or supplier was, within the preceding 10 years, convicted (as that term is defined in 42 CFR § 1001.2) of a federal or state felony offense that CMS determines to be detrimental to the best interests of the Medicare program and its beneficiaries. Offenses include, but are not limited in scope and severity to:

- Felony crimes against persons, such as murder, rape, assault, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions.

- Financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions.

- Any felony that placed the Medicare program or its beneficiaries at immediate risk, such as a malpractice suit that results in a conviction of criminal neglect or misconduct.

- Any felonies outlined in section 1128 of the Social Security Act.

While, as discussed in section 15.27.2(D) of this chapter, a re-enrollment bar will be established for providers and suppliers whose billing privileges are revoked, this does not preclude the contractor from denying re-enrollment to a provider or supplier that was convicted of a felony within the preceding 10-year period or that otherwise does not meet all of the criteria necessary to enroll in Medicare.

If the contractor is uncertain as to whether a particular felony falls within the purview of 42 CFR §424.530(a)(3), it should contact COPEU via the *MACRevocationRequests*@cms.hhs.gov mailbox for guidance.

Denial Reason 4 (42 CFR § 424.530(a)(4)) – False or Misleading Information on Application

The provider or supplier submitted false or misleading information on the enrollment application to gain enrollment in the Medicare program.

Denial Reason 5 (42 CFR § 424.530(a)(5)) – On-Site Review/Other Reliable Evidence that Requirements Not Met

Upon on-site review or other reliable evidence, CMS determines that the provider or supplier:
(i) Is not operational to furnish Medicare-covered items or services; or
(ii) Otherwise fails to satisfy any Medicare enrollment requirement.

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

(i) The enrolling provider, supplier, or owner (as defined in § 424.502) thereof has an existing Medicare debt.

(ii) The enrolling provider, supplier, or owner (as defined in § 424.502) thereof was previously the owner of a provider or supplier that had a Medicare debt that existed when the latter's enrollment was voluntarily terminated, involuntarily terminated, or revoked, and all of the following criteria are met:

(A) The owner left the provider or supplier with the Medicare debt within 1 year before or after that provider or supplier's voluntary termination, involuntary termination or revocation.

(B) The Medicare debt has not been fully repaid.

(C) CMS determines that the uncollected debt poses an undue risk of fraud, waste, or abuse. In making this determination under § 424.530(a)(6)(ii), CMS considers the following factors:

(1) The amount of the Medicare debt.
(2) The length and timeframe that the enrolling provider, supplier, or owner thereof was an owner of the prior entity.
(3) The percentage of the enrolling provider, supplier, or owner's ownership of the prior entity.
(4) Whether the Medicare debt is currently being appealed.
(5) Whether the enrolling provider, supplier, or owner thereof was an owner of the prior entity at the time the Medicare debt was incurred.

A denial of Medicare enrollment under paragraph (a)(6) can be avoided if the enrolling provider, supplier or owner thereof does either of the following:

(A) Satisfies the criteria set forth in § 401.607 and agrees to a CMS-approved extended repayment schedule for the entire outstanding Medicare debt; or

(B) Repays the debt in full.

Denial Reason 7 (42 CFR § 424.530(a)(7)) – Medicare Payment Suspension

The current owner (as defined in §424.502), physician or non-physician practitioner has been placed under a Medicare payment suspension as defined in § 405.370 through § 405.372.

Denial Reason 8 (42 CFR § 424.530(a)(8)) – Home Health Agency (HHA) Capitalization

An HHA submitting an initial application for enrollment:

- Cannot, within 30 days of a CMS or Medicare contractor request, furnish supporting documentation verifying that the HHA meets the initial reserve operating funds requirement in 42 CFR §489.28(a); or

- Fails to satisfy the initial reserve operating funds requirement in 42 CFR § 489.28(a).

Denial Reason 9 (42 CFR § 424.530(a)(9)) – Hardship Exception Denial and Fee Not Paid

The institutional provider's (as that term is defined in 42 CFR § 424.502) hardship exception request is not granted, and the institutional provider does not submit the required application fee within 30 days of notification that the hardship exception request was not approved.

(This denial reason should only be used when the institutional provider fails to submit the application fee after its hardship request was denied. The contractor shall use 42 CFR § 424.530(a)(1) as a basis for denial when the institutional provider:

- Does not submit a hardship exception request and fails to submit the application fee within the prescribed timeframes, or

- Submits the fee, but it cannot be deposited into a government-owned account.)

Denial Reason 10 (42 CFR § 424.530(a)(10)) – Temporary Moratorium

The provider or supplier submits an enrollment application for a practice location in a geographic area where CMS has imposed a temporary moratorium. (This denial reason applies to initial enrollment applications and practice location additions.)

Denial Reason 11 (42 CFR § 424.530(a)(11)) – DEA Certificate/State Prescribing Authority Suspension or Revocation

(i) A physician or eligible professional's Drug Enforcement Administration (DEA) Certificate of Registration to dispense a controlled substance is currently suspended or revoked; or

(ii) The applicable licensing or administrative body for any State in which a physician or eligible professional practices has suspended or revoked the physician or eligible professional's ability to prescribe drugs, and such suspension or revocation is in effect on the date the physician or eligible professional submits his or her enrollment application to the Medicare contractor.

B. Denial *Letters*

1. *Prior COPEU Approval Necessary*

For cases involving § 424.530(a)(4) (Denial Reason 4 above), the contractor shall obtain approval of both the denial and the denial letter from COPEU via the MACRevocationRequests@cms.hhs.gov mailbox prior to sending the denial letter. COPEU will notify the contractor of its determinations and instruct the contractor as to how to proceed.

2. *Prior COPEU Approval Unnecessary*

When a decision to deny is made, the contractor shall send a letter to the provider identifying the reason(s) for denial and furnishing appeal rights. The letter shall follow the format of those shown in section 15.24 et seq. of this chapter. Absent a CMS instruction or directive to the contrary, the letter shall be sent to the provider or supplier *no* later than 5 business days after the contractor concludes that the provider or supplier's application should be denied.

No reenrollment bar is established for denied applications. Reenrollment bars apply only to revocations.

C. Post-Denial Submission of Enrollment Application

A provider or supplier that is denied enrollment in the Medicare program may not submit a new enrollment application until either of the following has occurred:

- If the denial was not appealed, the provider or supplier's appeal rights have lapsed, or

- If the denial was appealed, the provider or supplier has received notification that the determination was upheld.

D. 30-Day Effective Date of Denial

A denial is effective 30 calendar days after the contractor sends its denial notice to the provider.

As stated in 42 CFR § 424.530(c), if the denial was due to adverse activity (e.g., exclusion, felony) of an owner, managing employee, an authorized or delegated official, medical director, supervising physician, or other health care personnel of the provider or supplier furnishing Medicare services, the denial may be reversed if the provider or supplier submits proof that it has terminated its business relationship with that individual or organization within 30 days of the denial notification.

E. Other Impacts of a Denial

1. Changes of Information and Changes of Ownership (CHOWs)

a. Expiration of Timeframe for Reporting Changes - If the contractor denies a change of information or CHOW submission per this section 15.8.4 and the applicable 90-day or 30-day period for reporting the change has expired, the contractor shall send an e-mail *to the MACRevocationRequests@cms.hhs.gov mailbox notifying COPEU of the denial*. COPEU will determine whether the provider's Medicare billing privileges should be deactivated under 42 CFR § 424.540(a)(2) or revoked under 42 CFR § 424.535(a)(1) or (a)(9) and will notify the contractor of its decision.

b. Timeframe Not Yet Expired - If the contractor denies a change of information or CHOW submission and the applicable 90-day or 30-day period for reporting the change has not yet expired, the contractor shall send the e-mail referred to in (1)(a) above after the expiration of said time period unless the provider has resubmitted the change request/CHOW.

c. Second Denial, Return, or Denial – If, per (1)(b), the provider resubmits the change of information or CHOW application and the contractor either denies it again, returns it per section 15.8.1 of this chapter, or rejects it per section 15.8.2 of this chapter, the contractor shall send the e-mail referred to in (1)(a) above regardless of whether the applicable timeframe has expired. COPEU will determine whether the provider's Medicare billing privileges should be deactivated under 42 CFR § 424.540(a)(2) or revoked under 42 CFR § 424.535(a)(1) or (a)(9) and will notify the contractor of its decision.

2. Reactivations – If the contractor denies a reactivation application, the provider's Medicare billing privileges shall remain deactivated.

3. Revalidations – If the contractor denies a revalidation application per this section 15.8.4, the contractor shall – unless an existing CMS instruction or directive dictates otherwise - revoke the provider's Medicare billing privileges under 42 CFR § 424.535(a)(1) if the applicable time period for submitting the revalidation application has expired. If it has not expired, the contractor shall revoke the provider's billing privileges after the applicable time period expires unless the provider has resubmitted the revalidation application. If the provider has resubmitted the application and the contractor (1) denies it again, (2) returns it per section 15.8.1 of this chapter, or (3) rejects it per section 15.8.2 of this chapter, the contractor shall - unless an existing CMS instruction or directive dictates otherwise – revoke the provider's billing privileges, assuming the applicable time period has expired.

F. Provider Enrollment Appeals Process

For more information regarding the provider enrollment appeals process, see section 15.25 of this chapte*r.*

15.20.1 - Site Verifications

(Rev 609., Issued: 08-14-15, Effective: 11-02-15, Implementation: 11-02-15)

(Unless otherwise stated in this chapter or in another CMS directive, this section 15.20.1 only applies to site visits/verifications that are not performed pursuant to sections 15.19.2.1 through 15.19.2.4 of this chapter.)

A. Background

1. Operational Status

When conducting a site verification to determine whether a practice location is operational, the contractor shall make every effort to limit its site verification to an external review of the practice location. If the contractor cannot determine whether the practice location is operational based on an external review of the location, the contractor shall conduct an unobtrusive site verification by limiting its encounter with provider or supplier personnel or medical patients.

2. Determining Whether the Provider or Supplier Meets Regulatory Requirements for Its Provider or Supplier Type

When conducting a site verification to determine whether a provider or supplier continues to meet the regulatory provisions for its provider or supplier type, the contractor shall conduct its site verification in a manner which limits the disruption for the provider or supplier.

B. Timing

Site verifications should be done Monday through Friday (excluding holidays) during their posted business hours. If there are no hours posted, the site verification should occur between 9 a.m. and 5 p.m. If, during the first attempt, there are obvious signs that facility is no longer operational no second attempt is required. If, on

the first attempt the facility is closed but there are no obvious indications the facility is non-operational, a second attempt on a different day during posted hours of operation should be made.

C. Documentation

When conducting site verifications to determine whether a practice location is operational, the contractor shall:

- Document the date and time of the attempted visit and include the name of the individual attempting the visit;

- As appropriate, photograph the provider or supplier's business for inclusion in the provider or supplier's file on an as needed basis. All photographs should be date/time stamped;

- Fully document all observations made at the facility (e.g., the facility was vacant and free of all furniture, a notice of eviction or similar documentation was posted at the facility, the space is now occupied by another company); and

- Write a report of its findings regarding each site verification.

D. Signed Declaration

The contractor shall also include a signed declaration stating the facts and verifying the completion of the site verification. (A sample declaration is below and may be revised as necessary.) *As a reminder, this declaration is only necessary for MAC-performed site visits.*

Declaration of (Name of Inspector/Investigator)
In the Case of _______________
Provider/Supplier No.___________

I, **(Name of Inspector/Investigator)**, declare as follows:

1. I have personal knowledge of each of the following matters in this Declaration except to those facts alleged on information and belief, and as to those matters, I believe them to be true. I am competent to testify to the following:

2. I am an Investigator for [Insert Contractor Name]. [Insert Contractor Name] is a CMS-contracted [Intermediary/Carrier/A/B Medicare Administrative Contractor (MAC)].

3. I have been trained as an Investigator and Site Inspector by [Insert Contractor Name], and I am knowledgeable of Medicare's compliance statutes, regulations and standards for suppliers enrolled in the Medicare program. I have worked in this capacity for [Insert years] years. During this period, I have conducted over [Insert Number] site inspections of the offices and facilities of providers/suppliers; and since January [Year in which case occurs], I have conducted over [Insert Number] site inspections related to the compliance of suppliers with Medicare's requirements.

4. I prepared the attached document entitled "[Title of Document]," which is the report of my attempts to inspect Petitioner's facility. This report is a true and accurate account of the events that occurred and transpired on the dates described therein. I am capable and willing to testify as a witness at a hearing about the content of this report.

5. The foregoing information is based on my personal knowledge or is information provided to me in my official capacity. I declare under penalty of perjury that this information is true and correct to the best of my knowledge and belief.

Executed this **_(Date)__** day of **_(Month) (Year)_** in **_(City)_**, **_(State)_**.

____
SIGNATURE OF DECLARANT

E. Determination

If a provider or supplier is determined not to be operational or not to be in compliance with the regulatory requirements for its provider/supplier type, the contractor shall revoke the Medicare billing privileges of the provider or supplier - unless the provider or supplier has submitted a change that notified the contractor of a change in practice location. Within 7 calendar days of CMS or the Medicare contractor determining that the provider or supplier is not operational, the Medicare contractor shall update PECOS or the applicable claims processing system (if the provider does not have an enrollment record in PECOS) to revoke billing Medicare billing privileges and issue a revocation notice to the provider or supplier. The Medicare contractor shall afford the provider or supplier applicable appeal rights in the revocation notification letter.

For non-operational status revocations, the contractor shall use either 42 CFR §424.535(a)(5)(i) or 42 CFR §424.535(a)(5)(ii) as the legal basis for revocation.

Consistent with 42 CFR §424.535(g), the date of revocation is the date on which CMS or the contractor determines that the provider or supplier is no longer operational. The Medicare contractor shall establish a 2-year enrollment bar for suppliers that are not operational.

For regulatory non-compliance revocations, the contractor shall use 42 CFR §424.535(a)(1) as the legal basis for revocation. Consistent with 42 CFR §424.535(g), the date of revocation is the date on which CMS or the contractor determines that the provider or supplier is no longer in compliance with regulatory provisions for their provider or supplier type. The Medicare contractor shall establish a 2-year enrollment bar for the providers and suppliers that are not in compliance with provisions for their enrolled provider or supplier type.

15.24.7.1 – Model Approval Letter

(Rev 609., Issued: 08-14-15, Effective: 11-02-15, Implementation: 11-02-15)

[month] [day], [year]

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

Reference # *(Contractor Control Number or NPI)*

Dear [Provider/Supplier Name]:

We are pleased to inform you that your [initial Medicare enrollment application]/[revalidated Medicare enrollment application]/[change of information request] is approved. This application is for the sole purpose of ordering and referring items or services for Medicare beneficiaries to other providers and suppliers. Listed below are your National Provider Identifier (NPI) and Provider Transaction Access Number (PTAN).

To start billing, you must use your NPI on all Medicare claim submissions. Because the PTAN is not considered a Medicare legacy identifier, do not report it as an "other" provider identification number to the National Plan and Provider Enumeration System (NPPES).

Your PTAN has been activated and will be the required authentication element for all inquiries to customer service representatives (CSRs), written inquiry units, and the interactive voice response (IVR) system. The IVR allows you to inquire about claims status, beneficiary eligibility and transaction information.

If you plan to file claims electronically, please contact our EDI department at [phone number].

Medicare Enrollment Information

Provider \ Supplier name:	[Name]
Practice location:	[Address]
National Provider Identifier (NPI):	[NPI]
Provider Transaction Access Number (PTAN):	[PTAN]
Specialty:	[Provider specialty]
You are a:	[participating]/[non-participating]
Effective date:	[Effective date or Effective date of termination]
Medicare Year-End Cost Report date:	[Date]

Please verify the accuracy of your enrollment information.

You are required to submit updates and changes to your enrollment information in accordance with specified timeframes pursuant to 42 CFR § 424.516. Reportable changes include, but are not limited to, changes in: (1) legal business name (LBN)/tax identification number (TIN), (2) practice location, (3) ownership, (4) authorized/delegated officials, (5) changes in payment information such as electronic funds transfer information and (6) final adverse legal actions, including felony convictions, license suspensions or revocations, an exclusion or debarment from participation in Federal or State health care program, or a Medicare revocation by a different Medicare contractor.

Providers and suppliers may enroll or make changes to their existing enrollment in the Medicare program using the Internet-based Provider Enrollment, Chain and Organization System (PECOS). Go to: www.cms.hhs.gov/MedicareProviderSupEnroll.

Providers and suppliers enrolled in Medicare are required to ensure strict compliance with Medicare regulations, including payment policy and coverage guidelines. CMS conducts numerous types of compliance reviews to ensure providers and suppliers are meeting this obligation. Please visit the Medicare Learning Network at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/index.html for further information about regulations and compliance reviews, as well as Continuing Medical Education (CME) courses for qualified providers.

Additional information about the Medicare program, including billing, fee schedules, and Medicare policies and regulations can be found at our Web site at [insert contractor's web address] or the Centers for Medicare & Medicaid Services (CMS) Web site at http://www.cms.hhs.gov/home/medicare.asp.

If you disagree with the effective date determination in this letter, you may request a reconsideration before a contractor hearing officer. The reconsideration is an independent review and will be conducted by a person who was not involved in the initial determination. You must request the reconsideration in writing to this office within 60 calendar days of the postmark date of this letter. The reconsideration must state the issues or findings of fact with which you disagree and the reasons for disagreement. You may submit the additional information with the reconsideration request that you believe may have a bearing on the decision. *However, if you have*

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

The reconsideration request must be signed and dated by the physician, non-physician practitioner or any responsible authorized or delegated official within the entity. Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review.

The reconsideration request should be sent 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]

15.24.8.1 – Model Denial Letter

(Rev 609., Issued: 08-14-15, Effective: 11-02-15, Implementation: 11-02-15)

[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]

If you believe that you are able to correct the deficiencies and establish your eligibility to participate in the Medicare program, you may submit a corrective action plan (CAP) within 30 calendar days after the postmark date of this letter. The CAP should provide evidence that you are in compliance with Medicare requirements.

The CAP request must be signed by the authorized or delegated official within the entity. CAP requests should be sent to:

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

If you believe that this determination is not correct, you may request a reconsideration before a contractor hearing officer. The reconsideration is an independent review and will be conducted by a person not involved in the initial determination. You must request the reconsideration in writing to this office within 60 calendar days of the postmark date of this letter. The reconsideration must state the issues or findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the reconsideration that you believe may have a bearing on the decision. *However, if you have additional information that you would like a hearing officer to consider during the reconsideration or, if necessary, an administrative law judge to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process; you will not have another opportunity to do so unless an administrative law judge specifically allows you to do so under 42 CFR § 498.56(e).*

The reconsideration must be signed and dated by the authorized or delegated official within the entity. Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review.

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

The reconsideration request should be sent to:

[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]

15.24.8.2 – Denial Example #1 – Discipline *N*ot *E*ligible

(Rev 609., Issued: 08-14-15, Effective: 11-02-15, Implementation: 11-02-15)

June 5, 2012

Xantippe Jones, LMFT
7824 Freudian Way
Yakima, WA 94054

Reference # *(Contractor Control Number or NPI)*

Dear Mr. Jones:

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.

If you believe that you are able to correct the deficiencies and establish your eligibility to participate in the Medicare program, you may submit a corrective action plan (CAP) within 30 calendar days after the postmark date of this letter. The CAP should provide evidence that you are in compliance with Medicare requirements. The CAP request must be signed by the authorized or delegated official within the entity. CAP requests should be sent to:

Medicare Administrative Contractor, Inc.
1234 Main St. – Attn: Hearing and Appeals, Room 510
Anytown, IL 12345

If you believe that this determination is not correct, you may request a reconsideration before a contractor hearing officer. The reconsideration is an independent review and will be conducted by a person not involved in the initial determination. You must request the reconsideration in writing to this office within 60 calendar days of the postmark date of this letter. The reconsideration must state the issues or findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the reconsideration that you believe may have a bearing on the decision. *However, if you have additional information that you would like a hearing officer to consider during the reconsideration or, if necessary, an administrative law judge to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process; you will not have another opportunity to do so unless an administrative law judge specifically allows you to do so under 42 CFR § 498.56(e).*

The reconsideration must be signed and dated by the authorized or delegated official within the entity. Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review.

The reconsideration request should be sent to:

Medicare Administrative Contractor, Inc.
1234 Main St. – Attn: Hearing and Appeals, Room 510
Anytown, IL 12345

If you have any questions, please contact our office at 601-555-1234 between the hours of 9:00 AM and 5:00 PM.

Sincerely,

Crispin Bacon
Provider Enrollment Analyst
Medicare Administrative Contractor, Inc.

15.24.8.3 – Denial Example #2 – Criteria for *E*ligible *D*iscipline *N*ot *M*et

(Rev 609., Issued: 08-14-15, Effective: 11-02-15, Implementation: 11-02-15)

June 7, 2012

Marjorie Gosling, NP
6578 Billings Avenue
Calgary, MI 42897

Reference # *(Contractor Control Number or NPI)*

Dear Ms. Gosling:

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.

If you believe that you are able to correct the deficiencies and establish your eligibility to participate in the Medicare program, you may submit a corrective action plan (CAP) within 30 calendar days after the postmark date of this letter. The CAP should provide evidence that you are in compliance with Medicare requirements. The CAP request must be signed by the authorized or delegated official within the entity. CAP requests should be sent to:

Medicare Administrative Contractor, Inc.
1234 Main St. – Attn: Hearing and Appeals, Room 510
Anytown, IL 12345

If you believe that this determination is not correct, you may request a reconsideration before a contractor hearing officer. The reconsideration is an independent review and will be conducted by a person not involved in the initial determination. You must request the reconsideration in writing to this office within 60 calendar days of the postmark date of this letter. The reconsideration must state the issues or findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the reconsideration that you believe may have a bearing on the decision. *However, if you have additional information that you would like a hearing officer to consider during the reconsideration or, if necessary, an administrative law judge to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process; you will not have another opportunity to do so unless an administrative law judge specifically allows you to do so under 42 CFR § 498.56(e).*

The reconsideration must be signed and dated by the authorized or delegated official within the entity. Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review.

The reconsideration request should be sent to:

Medicare Administrative Contractor, Inc.
1234 Main St. – Attn: Hearing and Appeals, Room 510
Anytown, IL 12345

If you have any questions, please contact our office at 601-555-1234 between the hours of 9:00 AM and 5:00 PM.

Sincerely,

Muffy McDowell
Provider Enrollment Analyst
Medicare Administrative Contractor, Inc.

15.24.8.4 –Denial Example #3 – Provider *S*tandards *N*ot *M*et

(Rev 609., Issued: 08-14-15, Effective: 11-02-15, Implementation: 11-02-15)

June 1, 2012

IDTF Services, Inc.
2498 Blood Draw Way
Eagle Rock, Arizona 98001

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.

If you believe that you are able to correct the deficiencies and establish your eligibility to participate in the Medicare program, you may submit a corrective action plan (CAP) within 30 calendar days after the postmark date of this letter. The CAP should provide evidence that you are in compliance with Medicare requirements. The CAP request must be signed by the authorized or delegated official within the entity. CAP requests should be sent to:

Medicare Administrative Contractor, Inc.
1234 Main St. – Attn: Hearing and Appeals, Room 510
Anytown, IL 12345

If you believe that this determination is not correct, you may request a reconsideration before a contractor hearing officer. The reconsideration is an independent review and will be conducted by a person not involved in the initial determination. You must request the reconsideration in writing to this office within 60 calendar days of the postmark date of this letter. The reconsideration must state the issues or findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the reconsideration that you believe may have a bearing on the decision. *However, if you have additional information that you would like a hearing officer to consider during the reconsideration or, if necessary, an administrative law judge to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process; you will not have another opportunity to do so unless an administrative law judge specifically allows you to do so under 42 CFR § 498.56(e).*

The reconsideration must be signed and dated by the authorized or delegated official within the entity. Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review.

The reconsideration request should be sent to:

Medicare Administrative Contractor, Inc.
1234 Main St. – Attn: Hearing and Appeals, Room 510
Anytown, IL 12345

If you have any questions, please contact our office at 601-555-1234 between the hours of 9:00 AM and 5:00 PM.

Sincerely,

Peaches Barkowicz
Provider Enrollment Analyst
Medicare Administrative Contractor, Inc.

15.24.8.5 – Denial Example #4 – *B*usiness *T*ype *N*ot *M*et

(Rev 609., Issued: 08-14-15, Effective: 11-02-15, Implementation: 11-02-15)

June 5, 2012

Roger Bain, M.S. CCC-SLP
6092 Wisconsin Way
Royal, MN 59034

Reference # *(Contractor Control Number or NPI)*

Dear Mr. Bain:

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.

If you believe that you are able to correct the deficiencies and establish your eligibility to participate in the Medicare program, you may submit a corrective action plan (CAP) within 30 calendar days after the postmark date of this letter. The CAP should provide evidence that you are in compliance with Medicare requirements. The CAP request must be signed by the authorized or delegated official within the entity. CAP requests should be sent to:

Medicare Administrative Contractor, Inc.
1234 Main St. – Attn: Hearing and Appeals, Room 510
Anytown, IL 12345

If you believe that this determination is not correct, you may request a reconsideration before a contractor hearing officer. The reconsideration is an independent review and will be conducted by a person not involved in the initial determination. You must request the reconsideration in writing to this office within 60 calendar days of the postmark date of this letter. The reconsideration must state the issues or findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the reconsideration that you believe may have a bearing on the decision. *However, if you have additional information that you would like a hearing officer to consider during the reconsideration or, if necessary, an administrative law judge to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process; you will not have another opportunity to do so unless an administrative law judge specifically allows you to do so under 42 CFR § 498.56(e).*

The reconsideration must be signed and dated by the authorized or delegated official within the entity. Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review.

The reconsideration request should be sent to:

Medicare Administrative Contractor, Inc.
1234 Main St. – Attn: Hearing and Appeals, Room 510
Anytown, IL 12345

If you have any questions, please contact our office at 601-555-1234 between the hours of 9:00 AM and 5:00 PM.

Sincerely,

Peaches Barkowicz
Applications Analyst

15.24.8.6 – Denial Example #5 – Existing or Delinquent Overpayments

(Rev 609., Issued: 08-14-15, Effective: 11-02-15, Implementation: 11-02-15)

Medicare Administrative Contractor Inc.
1234 Main Street
Anytown IL 12345
"Excellence in Health Care Services"

June 5, 2012

Xantippe Jones, LMFT
7824 Freudian Way
Yakima, WA 94054

Dear Mr. Jones:

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

Denial Reason 6 (42 CFR §424.530(a)(6))

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 (entered 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 or payments are currently being offset: Whether the overpayment is currently being appealed; the reason for the overpayment.

If you believe that you are able to correct the deficiencies and establish your eligibility to participate in the Medicare program, you may submit a corrective action plan (CAP) within 30 calendar days after the postmark date of this letter. The CAP should provide evidence that you are in compliance with Medicare requirements. The reconsideration request must be signed by the authorized or delegated official within the entity. CAP requests should be sent to:

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

If you believe that this determination is not correct, you may request a reconsideration before a contractor hearing officer. The reconsideration is an independent review and will be conducted by a person not involved in the initial determination. You must request the reconsideration in writing to this office within 60 calendar days of the postmark date of this letter. The reconsideration must state the issues or findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the reconsideration that you believe may have a bearing on the decision. *However, if you have additional information that you would like a hearing officer to consider during the reconsideration or, if necessary, an administrative law judge to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process; you will not have another opportunity to do so unless an administrative law judge specifically allows you to do so under 42 CFR § 489.56(e).*

The reconsideration must be signed and dated by the authorized or delegated official within the entity. Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review.

The reconsideration request should be sent to:

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

If you have any questions, please contact our office at 601-555-1234 between the hours of 9:00 AM and 5:00 PM.

Sincerely,

Crispin Bacon
Provider Enrollment Analyst
Medicare Administrative Contractor, Inc.

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

(Rev 609., Issued: 08-14-15, Effective: 11-02-15, Implementation: 11-02-15)

[Month] [day], [year]

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

Reference # *(Contractor Control Number or NPI)*

Dear [Provider/Supplier Name]:

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

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

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

If you believe that you are able to correct the deficiencies and establish your eligibility to participate in the Medicare program, and if this revocation is based in whole or in part on § 424.535(a)(1), you may submit a corrective action plan (CAP) within 30 calendar days after the postmark date of this letter. (Per 42 CFR §

405.879, a CAP cannot be accepted for revocations based exclusively on reasons other than § 424.535(a)(1). If the revocation is for multiple reasons of which one is § 424.535(a)(1), the CAP will only be reviewed with respect to the § 424.535(a)(1) basis for revocation.) The CAP should provide evidence that you are in compliance with Medicare requirements. The CAP request must be signed and dated by the authorized or delegated official within the entity. CAP requests should be sent to:

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

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

If you believe that this determination is not correct, you may request a reconsideration before a contractor hearing officer. The reconsideration is an independent review and will be conducted by a person not involved in the initial determination. You must request the reconsideration in writing to this office within 60 calendar days of the postmark date of this letter. The reconsideration must state the issues or findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the reconsideration that you believe may have a bearing on the decision. *However, if you have additional information that you would like a hearing officer to consider during the reconsideration or, if necessary, an administrative law judge to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process; you will not have another opportunity to do so unless an administrative law judge specifically allows you to do so under 42 CFR § 498.56(e).*

The reconsideration must be signed and dated by the authorized or delegated official within the entity. Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review.

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

The reconsideration request should be sent to:

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

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

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

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

Sincerely,

[Name]
[Title]
[Company]

15.24.10.2 – Favorable Corrective Action Plan/Reconsideration Decision – Denials
(Rev 609., Issued: 08-14-15, Effective: 11-02-15, Implementation: 11-02-15)

Provider Enrollment & Oversight Group (PEOG)

Month XX, 2015

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

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

Dear [provider/supplier/attorney]:

This letter is in response to the [Corrective Action Plan (CAP) and/or reconsideration] request received by the Centers for Medicare & Medicaid Services (CMS) in response to an enrollment denial effective Month XX, 201X. The initial determination letter by [MAC] was dated Month XX, 201X; therefore, this appeal is considered timely. The following decision is based on the Social Security Act, Medicare regulations, the CMS manual instructions, evidence in the file, and any information received before this decision was rendered.

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

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

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

SUBMITTED DOCUMENTATION [or] SUMMARY OF SUBMITTED DOCUMENTS:

- *Exhibit 1:*
- *Exhibit 2:*

CASE ANALYSIS:
All of the documentation in the file for [provider/supplier name] has been reviewed and the decision has been made in accordance with Medicare guidelines, as outlined in 42 CFR § 424.535.

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

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

Corrective Action Plan:
[Enter text]

Reconsideration:

[Enter text]

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

DECISION:
[Enter text]

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

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

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

Sincerely,

[Name]

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

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

15.24.10.3 – Favorable Corrective Action Plan/Reconsideration Decision – Revocations
(Rev 609., Issued: 08-14-15, Effective: 11-02-15, Implementation: 11-02-15)

Provider Enrollment & Oversight Group(PEOG)

Month XX, 2015

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

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

Dear [provider/supplier/attorney]:

This letter is in response to the [Corrective Action Plan (CAP) and/or reconsideration] request received by the Centers for Medicare & Medicaid Services (CMS) in response to a revocation, effective Month XX, 2015. The initial determination letter by [MAC] was dated Month XX, 2015; therefore, this appeal is considered timely. The following decision is based on the Social Security Act, Medicare regulations, the CMS manual instructions, evidence in the file, and any information received before this decision was rendered.

REVOCATION REASON: 42 CFR§ 425.535 (a)(fill reason 1-14)

> ***(b)*** *Reasons for revocation. CMS may revoke a currently enrolled provider or supplier's Medicare billing privileges and any corresponding provider agreement or supplier agreement for the following reasons:*
>
> *(Reason 1-14, copied from the Reg: link)*

[Insert language from the revocation letter stating why they are being revoked.]

SUBMITTED DOCUMENTATION [or] SUMMARY OF SUBMITTED DOCUMENTS:

- *Exhibit 1:*
- *Exhibit 2:*

CASE ANALYSIS:
All of the documentation in the file for [provider/supplier name] has been reviewed and the decision has been made in accordance with Medicare guidelines, as outlined in 42 CFR § 424.535.

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

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

Corrective Action Plan:
[Enter text]

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

DECISION:
[Enter text]

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

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

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

Sincerely,

[Name]

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

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

15.24.10.4 – Unfavorable Corrective Action Plan/Reconsideration Decision – Denials
(Rev 609., Issued: 08-14-15, Effective: 11-02-15, Implementation: 11-02-15)

Provider Enrollment & Oversight Group(PEOG)

Month XX, 2015

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

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

Dear [provider/supplier/attorney]:

This letter is in response to the [Corrective Action Plan (CAP) and/or reconsideration] request received by the Centers for Medicare & Medicaid Services (CMS) in response to an enrollment denial, effective Month XX, 2015. The initial determination letter by [MAC] was dated Month XX, 2015; therefore, this appeal is considered timely. The following decision is based on the Social Security Act, Medicare regulations, the CMS manual instructions, evidence in the file, and any information received before this decision was rendered.

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

(c) *Reasons for denial. CMS may deny a provider's or supplier's enrollment in the Medicare program for the following reasons:*

(Reason 1-11, copied from the Reg: link)

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

SUBMITTED DOCUMENTATION [or] SUMMARY OF SUBMITTED DOCUMENTS:

- *Exhibit 1:*
- *Exhibit 2:*

CASE ANALYSIS:
All of the documentation in the file for [provider/supplier name] has been reviewed and the decision has been made in accordance with Medicare guidelines, as outlined in 42 CFR § 424.535.

[The decision must include: A clear explanation of why PEOG is upholding the denial action in sufficient detail for the provider to understand PEOG's decision and; if applicable: the nature of the provider's deficiencies, the regulatory basis to support each reason for the denial, and an explanation of how the provider does not meet the enrollment criteria or requirements]

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

Corrective Action Plan:
[Enter text]

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

DECISION:
[Enter text]

CONCLUSION:
CMS concludes that there is no error made by [MAC] in the determination of an enrollment denial. The [CAP and/or reconsideration] is/are denied and the denial is upheld. Therefore, CMS has decided not to grant you access to the Medicare Trust Funds (by way or issuance) of a Medicare number.

*This decision is an **UNFAVORABLE DECISION**. Please see below for additional appeal rights.*

FURTHER APPEAL RIGHTS: ADMINISTRATIVE LAW JUDGE (ALJ):

If you are satisfied with this decision, you do not need to take further action. If you believe that this determination is not correct, you may request a final ALJ review. To do this, you must file your appeal within 60 calendar days after the date of receipt of this decision by writing to the following address:

Department of Health and Human Services
Departmental Appeals Board
Civil Remedies Division, Mail Stop 6132
330 Independence Avenue, S.W.
Cohen Building, Room G-644
Washington, D.C. 20201
Attn: CMS Enrollment Appeal

The following information is required with all ALJ requests:

- *Your legal business name*
- *Your Medicare PTAN (if applicable)*
- *Tax Identification Number (TIN) or Employer Identification Number (EIN)*
- *A copy of the Hearing Officer or the CMS Regional Office (RO) decision*

Alternatively, you can file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at https://dab.efile.hhs.gov/. *To file a new appeal using DAB E-File, you first need to register a new account by: (1) clicking Register on the DAB E-File home page; (2) entering the information requested on the "Register New Account" form; and (3) clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.*

The e-mail address and password provided during registration must be entered on the login screen at https://dab.efile.hhs.gov/user_sessions/new to access DAB E-File. A registered user's access to DAB E-File is restricted to the appeals for which he is a party or authorized representative. Once registered, you may file your appeal by:

- *Clicking the File New Appeal link on the Manage Existing Appeals screen, and then clicking Civil Remedies Division on the File New Appeal screen. And,*
- *Entering and uploading the requested information and documents on the "File New Appeal – Civil Remedies Division" form.*

At minimum, the Civil Remedies Division (CRD) requires a party to file a signed request for hearing and the underlying notice letter from CMS that sets forth the action taken and the party's appeal rights. All documents must be submitted in Portable Document Format ("PDF"). Any document, including a request for hearing, will be deemed to have been filed on a given day, if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day. A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the Administrative Law Judge, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service. More detailed instructions on DAB E-File for CRD cases can be found by clicking the CRD E-File Procedures link on the File New Appeal Screen for CRD appeals.

Appeal rights can be found at 42 CFR §498. The regulation explains the appeal rights following the determination by the CMS as to whether such entities [meet/continue to meet] the requirements for enrollment in the Medicare program.

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

Sincerely,

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

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

15.24.10.5 – Unfavorable Corrective Action Plan/Reconsideration Decision – Revocations
(Rev 609., Issued: 08-14-15, Effective: 11-02-15, Implementation: 11-02-15)

Provider Enrollment & Oversight Group(PEOG)

Month XX, 2015

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

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

Dear [provider/supplier/attorney]:

This letter is in response to the [Corrective Action Plan (CAP) and/or reconsideration] request received by the Centers for Medicare & Medicaid Services (CMS) in response to a revocation, effective Month XX, 2015. The initial determination letter by [MAC] was dated Month XX, 2015; therefore, this appeal is considered timely. The following decision is based on the Social Security Act, Medicare regulations, the CMS manual instructions, evidence in the file, and any information received before this decision was rendered.

REVOCATION REASON: 42 CFR§ 425.535 (a)(fill reason 1-14)

> ***(d)*** *Reasons for revocation. CMS may revoke a currently enrolled provider or supplier's Medicare billing privileges and any corresponding provider agreement or supplier agreement for the following reasons:*
>
> *(Reason 1-14, copied from the Reg: link)*

[Insert language from the revocation letter stating why they are being revoked.]

SUBMITTED DOCUMENTATION [or] SUMMARY OF SUBMITTED DOCUMENTS:

- *Exhibit 1:*
- *Exhibit 2:*

CASE ANALYSIS:
All of the documentation in the file for [provider/supplier name] has been reviewed and the decision has been made in accordance with Medicare guidelines, as outlined in 42 CFR §424.535.

[The decision must include: A clear explanation of why PEOG is not holding the revocation action in sufficient detail for the provider to understand PEOG's decision and; if applicable: the nature of the provider's deficiencies, the regulatory basis to support each reason for the revocation, and an explanation of how the provider/supplier still does not meet the enrollment criteria or requirements.]

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

Corrective Action Plan:
[Enter text]

Reconsideration:
[Enter text]

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

DECISION:
[Enter text]

This decision is an ***UNFAVORABLE DECISION****. Please see below for additional appeal rights.*

FURTHER APPEAL RIGHTS: ADMINISTRATIVE LAW JUDGE (ALJ):

If you are satisfied with this decision, you do not need to take further action. If you believe that this determination is not correct, you may request a final ALJ review. To do this, you must file your appeal within 60 calendar days after the date of receipt of this decision by writing to the following address:

Department of Health and Human Services
Departmental Appeals Board
Civil Remedies Division, Mail Stop 6132
330 Independence Avenue, S.W.
Cohen Building, Room G-644
Washington, D.C. 20201
Attn: CMS Enrollment Appeal

The following information is required with all ALJ requests:

- *Your legal business name*
- *Your Medicare PTAN (if applicable)*
- *Tax Identification Number (TIN) or Employer Identification Number (EIN)*
- *A copy of the Hearing Officer or the CMS Regional Office (RO) decision*

Alternatively, you can file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at https://dab.efile.hhs.gov/. *To file a new appeal using DAB E-File, you first need to register a new account by: (1) clicking Register on the DAB E-File home page; (2) entering the information requested on the "Register New Account" form; and (3) clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.*

The e-mail address and password provided during registration must be entered on the login screen at https://dab.efile.hhs.gov/user_sessions/new to access DAB E-File. A registered user's access to DAB E-File is restricted to the appeals for which he is a party or authorized representative. Once registered, you may file your appeal by:

- *Clicking the File New Appeal link on the Manage Existing Appeals screen, and then clicking Civil Remedies Division on the File New Appeal screen. And,*
- *Entering and uploading the requested information and documents on the "File New Appeal – Civil Remedies Division" form.*

At minimum, the Civil Remedies Division (CRD) requires a party to file a signed request for hearing and the underlying notice letter from CMS that sets forth the action taken and the party's appeal rights. All documents must be submitted in Portable Document Format ("PDF"). Any document, including a request for hearing, will be deemed to have been filed on a given day, if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day. A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the Administrative Law Judge, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service. More detailed instructions on DAB E-File for CRD cases can be found by clicking the CRD E-File Procedures link on the File New Appeal Screen for CRD appeals.

Appeal rights can be found at 42 CFR §498. The regulation explains the appeal rights following the determination by the CMS as to whether such entities [meet/continue to meet] the requirements for enrollment in the Medicare program.

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

Sincerely,

[Name]

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

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

15.25.1.2 – Reconsideration Requests – Non-Certified Providers/Suppliers

(Rev 609., Issued: 08-14-15, Effective: 11-02-15, Implementation: 11-02-15)

NOTE: *This section 15.25.1.2 does not apply to reconsiderations of revocations based wholly or partially on § 424.535(a)(8). Such reconsiderations are addressed in section 15.25.2.2 below.*

A. Timeframe for Submission

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

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

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

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

B. Signatures

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

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

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

C. Contractor's Receipt of Reconsideration Request

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

D. Reconsideration Determination

If a timely request for a reconsideration is made, the reconsideration shall be conducted by a HO or senior staff having expertise in provider enrollment and who was not involved in the (1) initial decision to deny or revoke enrollment, or (2) the CAP determination. The HO must hold an on-the-record reconsideration and issue a determination within 90 days of the date of the appeal request.

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

- The initial determination itself,

- The findings on which the initial determination was based,

- The evidence considered in making the initial determination, and

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

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

E. Issuance of Reconsideration Decision

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

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

- A summary of the documentation that the supplier provided;

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

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

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

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

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

If the HO overturns the contractor's decision, the contractor shall rescind the denial or revocation, issue or restore billing privileges (as applicable), and notify the supplier thereof via letter. For initial enrollments, the effective date of Medicare billing privileges is based on the date the supplier came into compliance with all Medicare requirements or the receipt date of the application – subject, of course, to any applicable "backbilling" restrictions. (See section 15.17 of this chapter for more information.) The contractor shall use the receipt date of the reconsideration request as the receipt date entered in the Provider Enrollment, Chain and Ownership System. For DMEPOS suppliers, the effective date is the date it is awarded by the National Supplier Clearinghouse.

F. Withdrawal of Reconsideration Request

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

G. Reports

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

15.25.2 - Appeals Involving Certified Providers and Certified Suppliers

(Rev 609., Issued: 08-14-15, Effective: 11-02-15, Implementation: 11-02-15)

Sections 15.25.2.1 through 15.25.2.3 below apply to:

- Providers and suppliers completing the Form CMS-855A
- Ambulatory surgical centers
- Portable x-ray suppliers

Also, section 15.25.2.2 applies to reconsiderations of revocations based wholly or partially on § 424.535(a)(8), regardless of provider or supplier type.

15.25.2.2 – Reconsideration Requests – Certified Providers and Certified Suppliers

(Rev 609., Issued: 08-14-15, Effective: 11-02-15, Implementation: 11-02-15)

This section 15.25.2.2 also applies to reconsiderations of revocations based wholly or partially on § 424.535(a)(8), regardless of provider or supplier type.

A. Timeframe for Submission

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

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

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

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

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

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

B. Signatures

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

C. Receipt of Reconsideration Request

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

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

D. Reconsideration Determination

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

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

- The initial determination itself,

- The findings on which the initial determination was based,

- The evidence considered in making the initial determination, and

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

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

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

E. Issuance of Reconsideration Decision

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

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

- A summary of the documentation that the provider furnished;

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

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

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

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

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

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

F. Withdrawal of Reconsideration Request

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

15.27.2 – Revocations

(Rev 609., Issued: 08-14-15, Effective: 11-02-15, Implementation: 11-02-15)

A. Revocation Reasons

(*Except as described in section 15.27.2(B)(2) below,* the contractor shall not issue any revocation or revocation letter without prior approval from CMS Central Office's provider enrollment unit (COPEU).)

When drafting a revocation letter (which, *except as described in section 15.27.2(B)(2) below,* must be sent to COPEU via the *MACRevocationRequests*@cms.hhs.gov mailbox for approval), the contractor shall insert the appropriate regulatory basis (e.g., 42 CFR § 424.535(a)(1)) into the letter. The contractor shall not use provisions from this chapter as the basis for revocation.

1. Revocation Reason 1 (42 CFR § 424.535(a)(1)) – Not in Compliance with Medicare Requirements

The provider or supplier is determined not to be in compliance with the enrollment requirements in subpart P (of Part 424) or in the enrollment application applicable to its provider or supplier type, and has not submitted a

plan of corrective action as outlined in 42 CFR Part 488. The provider or supplier may also be determined not to be in compliance if it has failed to pay any user fees as assessed under part 488 of this chapter.

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

Other situations in which § 424.535(a)(1) may be used as a revocation reason include, but are not limited to, the following:

a. The provider or supplier does not have a physical business address or mobile unit where services can be rendered.

b. The provider or supplier does not have a place where patient records are stored to determine the amounts due such provider or other person.

c. The provider or supplier is not appropriately licensed.

d. The provider or supplier is not authorized by the Federal/State/local government to perform the services that it intends to render.

e. The provider or supplier does not meet CMS regulatory requirements for the specialty that it is enrolled as.

f. The provider or supplier does not have a valid social security number (SSN) or employer identification number (EIN) for itself, an owner, partner, managing organization/employee, officer, director, medical director, and/or authorized or delegated official.

g. The provider or supplier fails to furnish complete and accurate information and all supporting documentation within 60 calendar days of the provider or supplier's notification from CMS or its contractor to submit an enrollment application and supporting documentation, or resubmit and certify to the accuracy of its enrollment information. (This revocation reason will not be used in these cases if CMS has explicitly instructed the contractor to use deactivation reason § 424.540(a)(3) in lieu thereof.)

h. The provider or supplier does not otherwise meet general enrollment requirements.

With respect to (e) above – and, as applicable, (c) and (d) - the contractor's revocation letter shall cite the appropriate statutory and/or regulatory citation(s) containing the specific licensure/certification/authorization requirement(s) for that provider or supplier type. For a listing of some of these statutes and regulations, refer to section 15.4 et seq. of this chapter.

NOTE: The contractor must identify in its revocation letter the exact provision within said statute(s)/regulation(s) that the provider/supplier is not in compliance with.

2. Revocation Reason 2 (42 CFR § 424.535(a)(2)) – Excluded/Debarred from Federal Program

The provider or supplier, or any owner, managing employee, authorized or delegated official, medical director, supervising physician, or other health care personnel of the provider or supplier is:

(i) Excluded from the Medicare, Medicaid, and any other Federal health care program, as defined in 42 CFR §1001.2, in accordance with section 1128, 1128A, 1156, 1842, 1862, 1867 or 1892 of the Act.

(ii) Is debarred, suspended, or otherwise excluded from participating in any other Federal procurement or nonprocurement program or activity in accordance with the FASA implementing regulations and the Department of Health and Human Services nonprocurement common rule at 45 CFR part 76.

If an excluded party is found, the contractor shall notify its PEBFL immediately. COPEU will notify the Contracting Officer's Representative (COR) for the appropriate Zone Program Integrity Contractor. The COR will, in turn, contact the Office of Inspector General's office with the findings for further investigation.

3. Revocation Reason 3 (42 CFR § 424.535(a)(3)) – Felony Conviction

The provider, supplier, or any owner or managing employee of the provider or supplier was, within the preceding 10 years, convicted (as that term is defined in 42 CFR § 1001.2) of a federal or state felony offense that CMS determines to be detrimental to the best interests of the Medicare program and its beneficiaries. Offenses include, but are not limited in scope and severity to:

(A) Felony crimes against persons, such as murder, rape, assault, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions.

(B) Financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions.

(C) Any felony that placed the Medicare program or its beneficiaries at immediate risk, such as a malpractice suit that results in a conviction of criminal neglect or misconduct.

(D) Any felonies that would result in mandatory exclusion under section 1128(a) of the Act.

(ii) Revocations based on felony convictions are for a period to be determined by the Secretary, but not less than 10 years from the date of conviction if the individual has been convicted on one previous occasion for one or more offenses.

An enrollment bar issued pursuant to 42 CFR § 424.535(c) does not preclude CMS or its contractors from denying re-enrollment to a provider or supplier that was convicted of a felony within the preceding 10-year period or that otherwise does not meet all criteria necessary to enroll in Medicare.

4. Revocation Reason 4 (42 CFR § 424.535(a)(4)) – False or Misleading Information on Application

The provider or supplier certified as ''true'' misleading or false information on the enrollment application to be enrolled or maintain enrollment in the Medicare program. (Offenders may be subject to either fines or imprisonment, or both, in accordance with current laws and regulations.)

5. Revocation Reason 5 (42 CFR § 424.535(a)(5)) - On-Site Review/Other Reliable Evidence that Requirements Not Met

Upon on-site review or other reliable evidence, CMS determines that the provider or supplier:

(i) Is not operational to furnish Medicare-covered items or services; or
(ii) Otherwise fails to satisfy any Medicare enrollment requirement.

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

(i) (A) An institutional provider does not submit an application fee or hardship exception request that meets the

requirements set forth in §424.514 with the Medicare revalidation application; or

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

(ii) (A) Either of the following occurs:

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

(2) The funds are not able to be credited to the United States Treasury;

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

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

7. Revocation Reason 7 (42 CFR § 424.535(a)(7)) – Misuse of Billing Number

The provider or supplier knowingly sells to or allows another individual or entity to use its billing number. This does not include those providers or suppliers that enter into a valid reassignment of benefits as specified in 42 CFR §424.80 or a change of ownership as outlined in 42 CFR §489.18.

8. Revocation Reason 8 (42 CFR § 424.535(a)(8)) – Abuse of Billing Privileges

Abuse of billing privileges includes either of the following:

(i) The provider or supplier submits a claim or claims for services that could not have been furnished to a specific individual on the date of service. These instances include but are not limited to the following situations:

(A) Where the beneficiary is deceased.

(B) The directing physician or beneficiary is not in the state or country when services were furnished.

(C) When the equipment necessary for testing is not present where the testing is said to have occurred.

(ii) CMS determines that the provider or supplier has a pattern or practice of submitting claims that fail to meet Medicare requirements. In making this determination, CMS considers, as appropriate or applicable, the following factors:

(A) The percentage of submitted claims that were denied.

(B) The reason(s) for the claim denials.

(C) Whether the provider or supplier has any history of final adverse actions (as that term is defined in § 424.502) and the nature of any such actions.

(D) The length of time over which the pattern has continued.

(E) How long the provider or supplier has been enrolled in Medicare.

(F) Any other information regarding the provider or supplier's specific circumstances that CMS deems relevant to its determination as to whether the provider or supplier has or has not engaged in the pattern or practice described in this paragraph.

(**NOTE**: With respect to (a)(8), CMS Central Office -- rather than the contractor -- will (1) make all determinations regarding whether a provider or supplier has a pattern or practice of submitting non-compliant claims; (2) consider the relevant factors; (3) accumulate all information needed to make such determinations; and (4) prepare and send all revocation letters.)

9. Revocation Reason 9 (42 CFR § 424.535(a)(9)) – Failure to Report Changes

The physician, non-physician practitioner, physician organization or non-physician organization failed to comply with the reporting requirements specified in 42 CFR §424.516(d)(1)(ii) or (iii), which pertain to the reporting of changes in adverse actions and practice locations, respectively, within 30 days of the reportable event.

With respect to Revocation Reason 9:

- This revocation reason only applies to physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse-midwives; clinical social workers; clinical psychologists; registered dietitians or nutrition professionals, and organizations (e.g., group practices) consisting of any of the categories of individuals identified in this paragraph.

- If the individual or organization reports a change in practice location more than 30 days after the effective date of the change, the contractor shall not pursue a revocation on this basis. However, if the contractor independently determines – through an on-site inspection under 42 CFR §424.535(a)(5)(ii) or via another verification process - that the individual's or organization's address has changed and the supplier has not notified the contractor of this within the aforementioned 30-day timeframe, the contractor may pursue a revocation (e.g., seeking COPEU's approval to revoke).

10. Revocation Reason 10 (42 CFR § 424.535(a)(10)) – Non-Compliance with Documentation Requirements

The provider or supplier did not comply with the documentation requirements specified in 42 CFR § 424.516(f).

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

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

12. Revocation Reason 12 (42 CFR § 424.535(a)(12)) – Medicaid Billing Privileges Revoked

The provider or supplier's Medicaid billing privileges are terminated or revoked by a State Medicaid Agency.

(Medicare may not terminate a provider or supplier's Medicare billing privileges unless and until the provider or supplier has exhausted all applicable Medicaid appeal rights).

13. Revocation Reason 13 (42 CFR § 424.535(a)(13)) - DEA Certificate/State Prescribing Authority Suspension or Revocation

(i) The physician or eligible professional's Drug Enforcement Administration (DEA) Certificate of Registration is suspended or revoked; or

(ii) The applicable licensing or administrative body for any state in which the physician or eligible professional practices suspends or revokes the physician or eligible professional's ability to prescribe drugs.

14. Revocation Reason 14 (42 CFR § 424.535(a)(14)) - CMS determines that the physician or eligible professional has a pattern or practice of prescribing Part D drugs that falls into one of the following categories:

(i) The pattern or practice is abusive or represents a threat to the health and safety of Medicare beneficiaries or both.

(ii) The pattern or practice of prescribing fails to meet Medicare requirements.

B. Prior COPEU Approval

1. Prior COPEU Approval Necessary

Except as described in section 15.27.2(B)(2) below, the contractor shall obtain approval of both the revocation and the revocation letter from COPEU via the *MACRevocationRequests*@cms.hhs.gov mailbox *prior to sending the revocation letter.* During *its* review, *COPEU* will also determine (1) the extent to which the revoked provider*'s* or supplier's other locations are affected by the revocation, (2) the geographic application of the reenrollment bar, and (3) the effective date of the revocation. *COPEU* will notify the contractor of its determinations and instruct the contractor as to how to proceed.

2. Prior COPEU Approval Unnecessary

The contractor need not obtain prior COPEU approval of the revocation and the revocation letter if the revocation involves any of the following situations:

- *Situation (a), (c), (d), (e), (g) or (h) under Revocation Reason 1 above*
- *§ 424.535(a)(6) or (a)(11)*

C. Effective Date of Revocations

Per 42 CFR § 424.535(g), a revocation becomes effective 30 days after CMS or the CMS contractor mails notice of its determination to the provider or supplier. However, a revocation based on a: (1) Federal exclusion or debarment; (2) felony conviction as described in 42 CFR § 424.535(a)(3); (3) license suspension or revocation; or (4) determination that the provider or supplier is no longer operational, is effective with the date of the exclusion, debarment, felony conviction, license suspension or revocation, or the date that CMS or the contractor determined that the provider or supplier is no longer operational.

(**NOTE:** In accordance with 42 CFR § 424.565, if a physician, non-physician practitioner, physician organization or non-physician practitioner organization fails to comply with the reporting requirements specified in 42 CFR § 424.516(d)(1)(ii), the contractor may assess an overpayment back to the date of the final adverse action, though said date shall be no earlier than January 1, 2009. Moreover, no later than 10 calendar days after the contractor assesses the overpayment, the contractor shall notify its PEBFL of the amount assessed.)

As stated in 42 CFR § 424.535(d), if the revocation was due to adverse activity (sanction, exclusion, debt, felony) of an owner, managing employee, an authorized or delegated official, medical director, supervising

physician, or other health care personnel of the provider or supplier furnishing Medicare services and/or supplies, the revocation may be reversed (with prior COPEU approval) if the provider or supplier submits proof that it has terminated its business relationship with that individual or organization within 30 days of the revocation notification. The contractor, however:

- Need not solicit or ask for such proof in its revocation letter. It is up to the provider/supplier to furnish this data on its own volition.

- Has the discretion to determine whether sufficient "proof" exists.

D. Re-enrollment Bar

As stated in 42 CFR § 424.535(c), if a provider, supplier, owner, or managing employee has their billing privileges revoked, they are barred from participating in the Medicare program from the effective date of the revocation until the end of the re-enrollment bar. The re-enrollment bar begins 30 days after CMS or its contractor mails notice of the revocation and lasts a minimum of 1 year, but not greater than 3 years, depending on the severity of the basis for revocation. (Felony convictions, however, always entail a 3-year bar.) Per § 424.535(c), the reenrollment bar does not apply if the revocation (1) is based on § 424.535(a)(1), and (2) stems from a provider or supplier's failure to respond timely to a revalidation request or other request for information. If both of these conditions are met, no reenrollment bar will be applied.

The contractor shall update the Provider Enrollment, Chain and Ownership System (PECOS) to reflect that the individual is prohibited from participating in Medicare for the applicable 1, 2, or 3-year period.

(**NOTE:** Reenrollment bars apply only to revocations, not to denials. The contractor shall not impose a reenrollment bar following a denial of an application.)

In general, and unless stated otherwise above, any re-enrollment bar at a minimum applies to (1) all practice locations under the provider's PECOS or legacy enrollment record, (2) any effort to re-establish any of these locations (i) at a different address, and/or (ii) under a different business or legal identity, structure, or TIN. If the contractor receives an application and is unsure as to whether a revoked provider is attempting to re-establish a revoked location, it shall contact its PEBFL for guidance. Instances where the provider might be attempting to do so include - but are not limited to – the following:

- John Smith was the sole owner of Group Practice X, a sole proprietorship. Six months after X was revoked under § 424.535(a)(9), the contractor receives an initial application from Group Practice Medicine, LLC, of which John Smith is the sole owner/member.

- Jack Jones and Stan Smith were 50 percent owners of World Home Health Agency, a partnership. One year after World Home Health was revoked under § 424.535(a)(7), the contractor receives an initial application from XYZ Home Health, a corporation owned by Jack Jones and his wife, Jane Jones.

- John Smith was the sole owner of XYZ Medical Supplies, Inc. XYZ's lone location was at 1 Jones Street. XYZ's billing privileges were revoked after it was determined that the site was non-operational. Nine months later, the contractor receives an initial application from Johnson Supplies, LLC. The entity has two locations in the same city in which 1 Jones Street is located, and John Smith is listed as a 75 percent owner.

E. Submission of Claims for Services Furnished Before Revocation

Per 42 CFR § 424.535(h), a revoked provider or supplier (other than a home health agency (HHA)) must, within 60 calendar days after the effective date of revocation, submit all claims for items and services furnished before the date of the revocation letter. A revoked HHA must submit all claims for items and services within 60 days after the later of: (1) the effective date of the revocation, or (2) the date that the HHA's last payable episode ends.

Nothing in 42 CFR § 424.535(h) impacts the requirements of § 424.44 regarding the timely filing of claims.

F. Timeframe for Processing of Revocation Actions

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

G. Provider Enrollment Appeals Process

For more information regarding the provider enrollment appeals process, see section 15.25 of this chapter.

H. Summary

If the contractor determines that a provider's billing privileges should be revoked, it shall undertake the activities described in this section, which include, but are not limited to:

- Preparing a draft revocation letter;
- E-mailing the letter to COPEU via the ProviderEnrollmentRevocations@cms.hhs.gov mailbox with additional pertinent information regarding the basis for revocation;
- Receiving COPEU's determinations and abiding by COPEU's instructions regarding the case;
- If COPEU authorizes the revocation:
  - Revoking the provider's billing privileges back to the appropriate date;
  - Establishing the applicable reenrollment bar;
  - Updating PECOS to show the length of the reenrollment bar;
  - Assessing an overpayment, as applicable; and
  - Affording appeal rights.

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

Section 6401(b)(2) of the Patient Protection and Affordable Health Care Act (i.e., the Affordable Care Act), enacted on March 23, 2010, requires that the Administrator of CMS establish a process for making available to each State Medicaid Plan or Child Health Plan the name, National Provider Identifier, and other identifying

information for any provider of medical or other items or services or supplier who have their Medicare billing privileges revoked or denied.

To accomplish this task, CMS will provide a monthly revoked and denied provider list to all contractors via the Share Point Ensemble site. The contractor shall access this list on the 5th day of each month through the Share Point Ensemble site. The contractor shall review the monthly revoked and denied provider list for the names of Medicare providers revoked and denied in PECOS. The contractor shall document any appeals actions a provider/supplier may have submitted subsequent to the provider or supplier's revocation or denial.

The contractor shall update the last three columns on the tab named "Filtered Revocations" of the spreadsheet for every provider/supplier revocation or denial action taken. The contractor shall not make any other modifications to the format of this form or its contents. The following terms are the only authorized entries to be made on the report:

Appeal Submitted:
Yes - (definition: an appeal has been received. This includes either a CAP or Reconsideration request or notification of an ALJ or DAB action.)
No - (definition: no appeal of any type has been submitted)

Appeal Type:
CAP
Reconsideration
ALJ
DAB

Appeal Status:
Under Review
Revocation Upheld
Revocation Overturned
Denial Upheld
Denial Overturned
CAP accepted
CAP denied
Reconsideration Accepted
Reconsideration Denied

If a contractor is reporting that no appeal has been submitted, the appeal type and status columns will be noted as N/A.

If an appeal action has been submitted to COPEU for certified providers or suppliers, contractors shall access the PEOG appeal's log via the Share Point Ensemble site to determine the appeal status to include on the spreadsheet.

Contractors shall submit their completed reports by the 20th of each month to its designated PEBFL.

J. Special Instructions Regarding Revocations of Certified Providers and Certified Suppliers

The contractor need not obtain prior approval from the state/RO prior to revoking a certified provider or certified supplier's billing privileges. When revoking the provider/supplier, however, the contractor shall:

- Notify the appropriate RO (via mail, E-mail, or fax contact) so that they may take the appropriate action to terminate the provider or supplier's Provider Agreement. A copy of the revocation letter shall be sent to the

applicable RO's Division of Survey & Certification corporate mailbox (the RO will notify the state of the revocation).

- After determining the effective date of the revocation, end-date the entity's enrollment record in the Provider Enrollment, Chain and Ownership System (PECOS) in the same manner as it would upon receipt of a tie-out notice from the RO.

- Afford the appropriate appeal rights per section 25 of this chapter.

15.28 – Deceased Practitioners

(Rev 609., Issued: 08-14-15, Effective: 11-02-15, Implementation: 11-02-15)

A. Reports of Death from the Social Security Administration (SSA)

Contractors, including DME MACs and the NSC MAC, will receive from CMS a monthly file that lists individuals who have been reported as deceased to the SSA. To help ensure that Medicare maintains current enrollment and payment information and to prevent others from utilizing the enrollment data of deceased individuals, the contractor shall undertake the activities described below.

B. Verification Activities for Individuals Other than Physicians, Non-Physician Practitioners and/or Suppliers of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)

(If the person is an owner, managing employee, director, officer, authorized official, etc., the contractor shall verify and document that the person is deceased using the process described in section (C)(1) *below*.)

Once the contractor verifies the report of death, it shall notify the provider or supplier organization with which the individual is associated that it needs to submit a Form CMS-855 change request that deletes the individual from the provider or supplier's enrollment record. If the provider fails to submit this information within 90 calendar days of the contractor's request, the contractor shall deactivate the provider's Medicare billing privileges in accordance with 42 CFR § 424.540(a)(2). (DMEPOS Suppliers Only - If a DMEPOS supplier fails to submit this information within 30 calendar days of the contractor's request, the contractor shall deactivate the supplier's billing privileges in accordance with 42 CFR § 424.57(c)(2).)

The contractor need not, however, solicit a Form CMS-855 change request if:

- The associate was the sole owner of his or her professional corporation or professional association. The contractor can simply take steps to deactivate that organization's enrollment in Medicare pursuant to section 15.27 of this chapter (e.g., seeking CMS approval); or

- The organization is enrolled with another contractor. Here, the contractor shall notify (via fax or e-mail) the contractor with which the organization is enrolled of the situation, at which time the latter contractor shall take actions consistent with this section 15.28.

C. Reports of Death from Third-Parties

1. Verification

If a contractor, including DME MACs or the NSC MAC, receives a report of death from a third-party (state provider association, state medical society, academic medical institution, etc.), the contractor shall verify that the physician, non-physician practitioner or DMEPOS supplier is deceased by:

- Obtaining oral or written confirmation of the death from an authorized or delegated official of the group practice to which the physician, non-physician practitioner or DMEPOS supplier had reassigned his or her benefits;

- Obtaining an obituary notice from the newspaper;

- Obtaining oral or written confirmation from the state licensing board (e.g., telephone, e-mail, computer screen printout);

- Obtaining oral or written confirmation from the State Bureau of Vital Statistics; or

- Obtaining a death certificate, Form SSA-704, or Form SSA-721 (Statement of Funeral Director).

2. Post-Confirmation Actions

Once the contractor verifies the death, it shall:

1. Undertake all actions normally associated with the deactivation of a supplier's billing privileges.

2. Search PECOS to determine whether the individual is listed therein as an owner, managing employee, director, officer, partner, authorized official, or delegated official of another supplier.

3. If the person is not in PECOS, no further action with respect to that individual is needed.

4. If the supplier is indeed identified in PECOS as an owner, officer, etc., the contractor shall notify the organization with which the person is associated that it needs to submit a Form CMS-855 change request that deletes the individual from the entity's enrollment record. If a provider fails to submit this information within 90 calendar days of the contractor's request, the contractor shall deactivate the provider's billing privileges in accordance with § 424.540(a)(2). (DMEPOS Suppliers Only - If a DMEPOS supplier fails to submit this information within 30 calendar days of the contractor's request, the contractor shall deactivate the supplier's billing privileges in accordance with § 424.57(c)(2).)

The contractor need not, however, ask for a Form CMS-855 change request if:

a. The physician, non-physician practitioner or DMEPOS supplier was the sole owner of his/hers professional corporation or professional association. The contractor can simply take steps to deactivate that organization's enrollment in Medicare pursuant to section 15.27 of this chapter ; or

b. The organization is enrolled with another contractor. In this situation, the contractor shall notify (via fax or e-mail) the contractor with which the organization is enrolled of the situation, at which time the latter contractor shall take actions consistent with this section 15.28.

The contractor shall place verification documentation in the provider or supplier file in accordance with section 15.7.3 of this chapter.

D. Education & Outreach

Contractors, including DME MACs and the NSC MAC, shall conduct outreach to state provider associations, state medical societies, academic medical institution, and group practices, etc., regarding the need to promptly inform contractors of the death of physicians and non-physician practitioners participating in the Medicare program.

E. Trustees/Legal Representatives

1. NPI - The trustee/legal representative of a deceased physician, non-physician practitioner or DMEPOS supplier's estate may deactivate the NPI of the deceased provider by providing written documentation to the NPI enumerator.

2. Special Payment Address - In situations where a physician, non-physician practitioner or DMEPOS supplier has died, the contractor can make payments to the individual's estate per the instructions in Pub. 100-04, chapter 1. When the contractor receives a request from the trustee or other legally-recognized representative of the physician, non-physician practitioner or DMEPOS supplier's estate to change the physician, non-physician practitioner or DMEPOS supplier's special payment address, the contractor shall, at a minimum, ensure that the following information is furnished:

- Form CMS-855 change of information request that updates the "Special Payment" address in the application. The Form CMS-855 can be signed by the trustee/legal representative.

- Any evidence – within reason - verifying that the physician, non-physician practitioner or DMEPOS supplier is in fact deceased.

- Legal documentation verifying that the trustee/legal representative has the legal authority to act on behalf of the provider, non-physician practitioner or DMEPOS supplier's estate.

The policies in this section 15.28(E)(1) and (2) apply only to physicians, non-physician practitioners and DMEPOS suppliers who operated their business as sole proprietors. It does not apply to solely-owned corporations, limited liability companies, etc., nor to situations in which the physician or non-physician practitioner reassigned his or her benefits to another entity.