CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-08 Medicare Program Integrity	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 636	**Date: February 4, 2016**
	Change Request 9390

SUBJECT: Update to Pub. 100-08, Chapter 15

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) clarifying the process for verifying correspondence telephone numbers; (2) clarifying the process for validating the credentials of technicians of independent diagnostic testing facilities; and (3) identifying the timeframe by which approval letters must be sent and to whom they must be sent.

EFFECTIVE DATE: March 4, 2016
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: March 4, 2016
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	15/15.1.3/Medicare Contractor Duties
R	15/15.5.2.2/Correspondence Address and E-mail Addresses
R	15/15.5.6.1/Tax Identification Numbers (TINs) of Owning and Managing Organizations and Individuals
R	15/15.5.15.2/Form CMS-855A and Form CMS-855B Signatories
R	15/15.5.16/Delegated Officials
R	15/15.5.19.4/Technicians
R	15/15.5.19.5/Supervising Physicians
R	15/15.5.20/Processing Form CMS-855R Applications
R	15/15.5.20.1/Inter-Jurisdictional Reassignments
R	15/15.6.1.1.1/Form CMS-855 Applications That Require a Site Visit
R	15/15.6.1.1.2/Form CMS-855 Applications That Do Not Require a Site Visit
R	15/15.6.3/General Timeliness Principles
R	15/15.7.1.2/Receipt/Review of Internet-Based PECOS Applications
R	15/15.7.1.3/Verification of Data/Processing Alternatives
R	15/15.7.5/Special Program Integrity Procedures
R	15/15.7.7.2/Tie-In/Tie-Out Notices and Referrals to the State/RO
R	15/15.7.8.4/Ambulatory Surgical Centers (ASCs)/Portable X-ray Suppliers (PXRS) Tie-In/Tie-Out Notices and Referrals to the State/RO
R	15/15.7.9.3/Processing of Registration Applications
R	15/15.7.9.4/Disposition of Registration Applications
R	15/15.7.9.5/Revocation of Registration
R	15/15.7.9.7/Registration Letters
R	15/15.8.1/Returns
R	15/15.8.4/Denials
R	15/15.9.1/Non-Certified Suppliers and Individual Practitioners
R	15/15.13/Existing or Delinquent Overpayments
R	15/15.14.2/Contractor Communications
R	15/15.19.1/Application Fees
R	15/15.19.2.5/Movement of Providers and Suppliers into the High Level
R	15/15.22.1/Web Sites

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	15/15.23.2/Release of Information
R	15/15.24/Model Letter Guidance
R	15/15.24.7/Approval Letter Guidance
R	15/15.25/Appeals Process
R	15/15.25.1.1/Corrective Action Plans (CAPs)
R	15/15.25.1.2/Reconsideration Requests – Non-Certified Providers/Suppliers
R	15/15.25.2.1/Corrective Action Plans (CAPs)
R	15/15.25.2.2/Reconsideration Requests – Certified Providers and Certified Suppliers
R	15/15.26.1/HHA Ownership Changes
R	15/15.27.2/Revocations
R	15/15.27.3/Other Identified Revocations
R	15/15.27.4/External Reporting Requirements
R	15/15.29.6/Reserved for Future Use

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: 636	Date: February 4, 2016	Change Request: 9390

SUBJECT: Update to Pub. 100-08, Chapter 15

EFFECTIVE DATE: March 4, 2016
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: March 4, 2016

I. GENERAL INFORMATION

A. Background: Pub. 100-08, Chapter 15 contains instructions regarding the processing of Form CMS-855 applications. The principal purpose of this change request (CR) is to clarify certain aspects of the application process, such as-- (1) the verification of correspondence telephone numbers; (2) the validation of the credentials of technicians of independent diagnostic testing facilities (IDTFs); and (3) the timeframe by which approval letters must be sent and to whom they must be sent.

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	
9390.1	If online verification of an IDTF technician's credentials is not available or cannot be made, the contractor shall request a copy of the technician's certification card.		X							
9390.2	The contractor shall not request a social security card to verify an individual's identity or social security number.	X	X	X						
9390.3	The contractor shall adhere to the instructions in section 15.27.2 of chapter 15 with respect to revoking a certified provider's/certified supplier's enrollment based on the termination of the provider's/supplier's agreement.	X	X	X						
9390.4	Absent a CMS instruction or directive to the contrary, the contractor shall send enrollment approval letters within 5 business days of approving the enrollment application in PECOS.	X	X	X						
9390.4.1	For all applications other than the Form CMS-855S,	X	X	X						

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	the contractor shall send development/approval letters/revocation letters, etc., to the contact person if one is listed; otherwise, the contractor may send the letter to the provider or supplier at the provider's/supplier's correspondence address or special payments address.									

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
9390.5	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within 5 business days after receipt of the notification from CMS announcing the availability of the article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X	X	X		

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

Table of Contents
(Rev.636, Issued: 02-04-16)

15.1.3 – Medicare Contractor Duties

(Rev. 636, Issued: 02-04-16, Effective: 03-04-16- Implementation: 03-04-16)

The contractor shall adhere to all of the instructions in this chapter 15 (hereafter generally referred to as "this chapter") and all other CMS provider enrollment directives (e.g., Technical Direction letters). The contractor shall also assign the appropriate number of staff to the Medicare enrollment function to ensure that all such instructions and directives - including application processing timeframes and accuracy standards - are complied with and met.

A. Training

The contractor shall provide (1) training to new employees, and (2) refresher training (as necessary) to existing employees to ensure that each employee processes enrollment applications in a timely, consistent, and accurate manner. Training shall include, at a minimum:

- An overview of the Medicare program
- A review of all applicable regulations, manual instructions, and other CMS guidance
- A review of the contractor's enrollment processes and procedures
- Training regarding the Provider Enrollment, Chain and Ownership System (PECOS).

For new employees, the contractor shall also:

- Provide side-by-side training with an experienced provider enrollment analyst
- Test the new employee to ensure that he or she understands Medicare enrollment policy and contractor processing procedures, including the use of PECOS
- Conduct end-of-line quality reviews for 6 months after training or until the analyst demonstrates a clear understanding of Medicare enrollment policy, contractor procedures, and the proper use of PECOS.

B. PECOS

The contractor shall:

- Process all enrollment actions (e.g., initials, changes, revalidations) through PECOS
- Deactivate or revoke the provider or supplier's Medicare billing privileges in the Multi-Carrier System or the Fiscal Intermediary Shared System only if the provider or supplier is not in PECOS
- Close or delete any aged logging and tracking (L & T) records older than 120 days for which there is no associated enrollment application
- Participate in user acceptance testing for each PECOS release
- Attend scheduled PECOS training when requested
- Report PECOS validation and production processing problems through the designated tracking system for each system release

- Develop (and update as needed) a written training guide for new and current employees on the proper processing of Form CMS-855 applications and the appropriate entry of data into PECOS.

C. Validation and Processing

The contractor shall:

- Review the application to determine whether it is complete and that all information and supporting documentation required for the applicant's provider/supplier type has been submitted on and with the appropriate enrollment application. Unless stated otherwise in this chapter or in another CMS directive, the provider must complete all required data elements on the Form CMS-855 via the application itself.

- Unless stated otherwise in this chapter or in another CMS directive, verify and validate all information collected on the enrollment application

- Coordinate with State survey/certification agencies and regional offices (ROs), as needed

- Collect and maintain the application's certification statement (in house) to verify and validate Electronic Funds Transfer (EFT) changes in accordance with the instructions in this chapter and all other CMS directives.

- Confirm that the applicant, all individuals and entities listed on the application, and any names or entities ascertained through other sources, are not presently excluded from the Medicare program by the HHS Office of the Inspector General (OIG) or through the System for Award Management.

D. Customer Service

Excluding matters pertaining to application processing (e.g., development for missing data) and appeals (e.g., appeal of revocation), the contractor is encouraged to respond to all enrollment-related provider/supplier correspondence (e.g., e-mails, letters, telephone calls) within 30 business days of receipt.

15.5.2.2 – Correspondence Address and E-mail Addresses

(Rev. 636, Issued: 02-04-16, Effective: 03-04-16- Implementation: 03-04-16)

A. Correspondence Address

The correspondence address must be one where the contractor can directly contact the applicant to resolve any issues once the provider is enrolled in the Medicare program. It cannot be the address of a billing agency, management services organization, chain home office, or the provider's representative (e.g., attorney, financial advisor). It can, however, be a P.O. Box or, in the case of an individual practitioner, the person's home address.

B. Correspondence Telephone Number

The provider may list any telephone number it wishes as the correspondence phone number. The number need not link to the listed correspondence address. *If the provider fails to list a correspondence telephone number, the contractor shall develop for this information via the procedures outlined in this chapter.*

C. E-mail Addresses

An e-mail address listed on the application can be a generic e-mail address. It need not be that of a specific individual. The contractor may accept a particular e-mail address if it has no reason to suspect that it does not belong to or is not somehow associated with the provider.

D. Contact Persons

Unless stated otherwise in this chapter or in another CMS directive - or unless the provider requests that the contractor communicate with only a specific individual (e.g., an authorized official) or via specific means (e.g., only via the correspondence e-mail address) - the contractor has the discretion to use the contact persons listed in section 13 of the Form CMS-855 for all written and oral communications (e.g., mail, e-mail, telephone) related to the provider's Medicare enrollment. Such communication need not be restricted to a particular enrollment application of the provider's that the contractor is currently processing. Nor is the contractor required (again, unless either CMS or the provider directs otherwise) to send certain materials to the correspondence mailing or e-mail address rather than the contact person's mailing or e-mail address.

15.5.6.1 – Tax Identification Numbers (TINs) of Owning and Managing Organizations and Individuals

(Rev. 636, Issued: 02-04-16, Effective: 03-04-16- Implementation: 03-04-16)

Consistent with sections 1124 and 1124A of the Social Security Act, the TINs (employer identification numbers or social security numbers) of all entities and individuals listed in sections 5 and 6, respectively, of the Form CMS-855 must be disclosed. If the contractor receives an initial, reactivation, revalidation, or change of ownership application from a provider and the provider fails to disclose the TIN of a particular organization or individual listed in section 5 or 6, the contractor shall follow normal development procedures for requesting the TIN. In doing so, if the contractor learns or determines that the TIN was not furnished because the entity or person in question is foreign, the contractor shall take the following steps:

a. The contractor shall ask the provider (via any means) whether the person or entity is able to obtain a TIN or, in the case of individuals, an individual taxpayer identification number (ITIN). (Only one inquiry is needed.)

   (1) If the provider fails to respond to the contractor's inquiry within 30 days, the contractor shall follow the instructions in (c) below.

   (2) If the provider states that the person or entity is able to obtain a TIN or ITIN, the contractor shall send an e-mail, fax, or letter to the provider stating that (i) the person or entity must obtain a TIN/ITIN, and (ii) the provider must furnish the TIN/ITIN on the Form CMS-855 with a newly-signed certification statement within 90 days of the contractor's request.

   (3) If the provider states that the person or entity is unable to obtain a TIN or ITIN, the contractor shall send an e-mail, fax, or letter to the provider stating that (i) the provider must submit written documentation to the contractor explaining why the person or entity cannot legally obtain a TIN or ITIN, and (ii) the explanation – which can be in any written format and may be submitted electronically or via fax – must be submitted within 30 days of the contractor's request.

b. If the provider timely submits the explanation in (a)(3) above, the contractor shall forward the explanation to its *CMS* Provider Enrollment *& Oversight* Group Business Function Lead (PEOG BFL). PEOG will notify the contractor as to how the application should be handled.

c. If the provider fails to timely respond to the contractor's inquiry in (a) or fails to timely furnish the TIN/ITIN in (a)(2), the contractor shall – unless another CMS instruction directs otherwise - reject the application in accordance with the procedures identified in this chapter.

In addition:

- If the contractor exceeds timeliness standards on a particular application because of the procedures outlined in this section, the contractor shall document the provider file in accordance with section 15.7.3 of this chapter.

For purposes of this section 15.5.6.1 only, the term "change of ownership" - as used in the first paragraph of this section - refers to (1) CHOW, acquisition/merger, and consolidation applications submitted by the new owner, (2) change in majority ownership applications submitted by a home health agency, and (3) change of information applications in which a new entity or individual (e.g., owner, managing employee, corporate director) is being added in section 5 or 6.

15.5.19.4 – Technicians

(Rev. 636, Issued: 02-04-16, Effective: 03-04-16- Implementation: 03-04-16)

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

A. Licensure and Certification -- All technicians must meet the standards of a *s*tate license or *s*tate certification at the time of the IDTF's enrollment. *The* contractor may not grant temporary exemptions from such requirements.

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

B. Changes of Technicians

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

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

15.5.19.5 – Supervising Physicians

(Rev. 636, Issued: 02-04-16, Effective: 03-04-16- Implementation: 03-04-16)

A. General Principles

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

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

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

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

B. Information about Supervising Physicians

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

In addition:

- Each physician of the group who actually performs an IDTF supervisory function must be listed.

- If a supervising physician has been recently added or changed, the updated information must be reported via a Form CMS-855B change request. The new physician must have met all of the supervising physician requirements at the time any tests were performed.

- If the contractor knows that a listed supervising physician has been listed with several other IDTFs, the contractor shall check with the physician to determine whether he or she is still acting as supervising physician for these other IDTFs.

- If the supervising physician is enrolling in Medicare and does not intend to perform medical services outside of his/her role as a supervising physician:

    - The contractor shall still send the physician an approval letter (assuming successful enrollment) and issue a Provider Transaction Access Number

    - The physician shall list the IDTF's address as a practice location

    - The space-sharing prohibition in 42 CFR § 410.33(g) does not apply in this particular scenario.

C. General, Direct, and Personal Supervision

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

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

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

D. Attestation Statement for Supervising Physicians

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

With respect to physician verification, the contractor shall:

- Check the signature on the attestation against that of the enrolled physician.

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

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

15.5.15.2 – Form CMS-855A and Form CMS-855B Signatories *(Rev. 636, Issued: 02-04-16, Effective: 03-04-16- Implementation: 03-04-16)*

For *Form* CMS-855A and CMS-855B initial applications, the certification statement must be signed and dated by an authorized official of the provider. (See section 15.1.1 of this chapter for a definition of "authorized official.") The provider can have an unlimited number of authorized officials, so long as each meets the definition of an authorized official. Section 6 of the Form CMS-855 must be completed for each authorized official.

If an authorized official is listed as a "Contracted Managing Employee" in section 6 of the Form CMS-855 and does not qualify as an authorized official under some other category in section 6, he/she cannot be an authorized official. The contractor shall notify the provider accordingly. If the person is not listed as a "Contracted Managing Employee" in section 6 and the contractor has no reason to suspect that the person does not qualify as an authorized official, no further investigation is required. Should the contractor have doubts that the individual qualifies as an authorized official, it shall contact the official or the applicant's contact person to obtain more information about the official's job title and/or authority to bind. If the contractor remains unconvinced that the individual qualifies as an authorized official, it shall notify the provider that the person cannot be an authorized official. If that person is the only authorized official listed and the provider refuses to use a different authorized official, the contractor shall deny the application.

An authorized official must be a 5 percent direct owner, chairman of the board, etc., of the enrolling provider. One cannot use his/her status as the chief executive officer, chief financial officer, etc., of the provider's parent company, management company, or chain home office as a basis for his/her role as the provider's authorized official.

In addition:

1. Original Signatures - For non-electronic signatures, the signature of an authorized official must be original. Faxed, stamped, or photocopied signatures cannot be accepted.

2. Deletion of Authorized Official - If an authorized official is being deleted, the contractor need not obtain (1) that official's signature, or (2) documentation verifying that the person is no longer an authorized official.

3. Change in Authorized Officials - A change in authorized officials does not impact the authority of existing delegated officials to report changes and/or updates to the provider's enrollment data *or to sign revalidation applications.*

4. Authorized Official Not on File - If the provider submits a change of information (e.g., change of address) and the authorized official signing the form is not on file, the contractor shall ensure that: (1) the person meets the definition of an authorized official, and (2) section 6 of the Form CMS-855 is completed for that person. The signature of an existing authorized official is not needed in order to add a new authorized official. Note that the original change request and the addition of the new official shall be treated as a single change request (i.e., one change request encompassing two different actions) for purpose of enrollment processing and reporting.

5. Effective Date - The effective date in the Provider Enrollment, Chain and Ownership System for section 15 of the Form CMS-855 should be the date of signature.

6. Social Security Number - To be an authorized official, the person must have and must submit his/her social security number (SSN). An Individual Taxpayer Identification Number (ITIN) cannot be used in lieu of an SSN in this regard.

7. Identifying the Provider – As stated earlier, an authorized official must be an authorized official of the

provider, not of an owning organization, parent company, chain home office, or management company. Identifying the provider is not - for purposes of determining an authorized official's qualifications - determined solely by the provider's tax identification number (TIN). Rather, the organizational structure is the central factor. For instance, suppose that a chain drug store, Company X, wants to enroll 100 of its pharmacies with the contractor. Each pharmacy has a separate TIN and must therefore enroll separately. Yet all of the pharmacies are part of a single corporate entity – Company X. In other words, there are not 100 separate corporations in our scenario, but merely one corporation whose individual locations have different TINs. Here, an authorized official for Pharmacy #76, can be someone at X's headquarters (assuming that the definition of authorized official is otherwise met), even though this main office might be operating under a TIN that is different from that of #76. This is because headquarters and Pharmacy #76 are part of the same organization/corporation. Conversely, if #76 was a corporation that was separate and distinct from Company X, only individuals that were part of #76 could be authorized officials.

8. Certification Statement Development – When the contractor develops for missing or additional information and the provider must submit a newly-signed certification statement, only the actual signature page is required; the additional page containing the certification terms need not be submitted unless the contractor requests it. This does not apply, however, to the provider's initial submission of a certification statement for a particular application; such instances require the submission of both the signature page and the page containing the certification terms. To illustrate, suppose the provider submits an initial *Form* CMS-855 application with an undated certification statement. The provider must furnish a newly-dated (and signed) certification statement and the certification terms page; it does so on March 1. On March 15, the contractor determines that information on section 4 of the provider's application is incorrect and must be revised. When submitting the revised section 4 page, the provider need only furnish a newly-signed signature page; the certification terms page need not be submitted unless the contractor requests it.

15.5.16 – Delegated Officials

(Rev. 636, Issued: 02-04-16, Effective: 03-04-16- Implementation: 03-04-16)

(Unless indicated otherwise below or in another CMS directive, the instructions in this section apply to (1) signatures on the paper Form CMS-855, (2) signatures on the certification statement for Internet-based Provider Enrollment, Chain and Ownership System (PECOS) applications, and (3) electronic signatures. (**NOTE**: This section only applies to the Form CMS-855A and the Form CMS-855B.))

A delegated official is an individual to whom an authorized official listed in section 15 of the Form CMS-855 delegates the authority to report changes and updates to the provider's enrollment record *or to sign revalidation applications*. The delegated official must be an individual with an "ownership or control interest" in (as that term is defined in § 1124(a)(3) of the Social Security Act), or be a W-2 managing employee of the provider.

Section 1124(a)(3) defines an individual with an ownership or control interest as:

- A five percent direct or indirect owner of the provider,
- An officer or director of the provider (if the provider is a corporation), or
- Someone with a partnership interest in the provider, if the provider is a partnership

The delegated official must be a delegated official of the provider, not of an owning organization, parent company, chain home office, or management company. One cannot use his/her status as a W-2 managing employee of the provider's parent company, management company, or chain home office as a basis for his/her role as the provider's delegated official.

The contractor shall note the following about delegated officials:

1. Authority - A delegated official has no authority to sign an initial application. However, the delegated official *may (i) sign a revalidation application and (ii) sign off* on changes/updates submitted in response to a contractor's request to clarify or submit information needed to continue processing the provider's initial application.

2. Section 6 – Section 6 of the Form CMS-855 must be completed for all delegated officials.

3. Managing Employees - For purposes of section 16 only, the term "managing employee" means any individual, including a general manager, business manager, or administrator, who exercises operational or managerial control over the provider, or who conducts the day-to-day operations of the provider. However, this does not include persons who, either under contract or through some other arrangement, manage the day-to-day operations of the provider but who are not actual W-2 employees. For instance, suppose the provider hires Joe Smith as an independent contractor to run its day-to-day-operations. Under the definition of "managing employee" in section 6 of the Form CMS-855, Smith would have to be listed in that section. Yet under the section 16 definition (as described above), Smith cannot be a delegated official because he is not an actual W-2 employee of the provider. Independent contractors are not considered "managing employees" under section 16 of the Form CMS-855.

4. W-2 Form – Unless the contractor requests it to do so, the provider is not required to submit a copy of the owning/managing individual's W-2 to verify an employment relationship.

5. Number of Delegated Officials - The provider can have as many delegated officials as it chooses. Conversely, the provider is not required to have any delegated officials. Should no delegated officials be listed, the authorized official(s) remains the only individual(s) who can report changes and/or updates to the provider's enrollment data.

6. Effective Date - The effective date in PECOS for section 16 of the Form CMS-855 should be the date of signature.

7. Social Security Number - To be a delegated official, the person must have and must submit his/her social security number. An Individual Taxpayer Identification Number (ITIN) cannot be used in lieu of an SSN in this regard.

8. Deletion - If a delegated official is being deleted, documentation verifying that the person no longer is or qualifies as a delegated official is not required. Also, the signature of the deleted official is not needed.

9. Further Delegation - Delegated officials may not delegate their authority to any other individual. Only an authorized official may delegate the authority to make changes and/or updates to the provider's Medicare data *or to sign revalidation applications.*

10. Delegated Official Not on File - If the provider submits a change of information (e.g., change of address) and the delegated official signing the form is not on file, the contractor shall ensure that (1) the person meets the definition of a delegated official, (2) section 6 of the Form CMS-855 is completed for that person, and (3) an existing authorized official signs off on the addition of the delegated official. (**NOTE**: The original change request and the addition of the new official shall be treated as a single change request (i.e., one change request encompassing two different actions) for purpose of enrollment processing and reporting.)

11. Signature on Paper Application - If the provider submits a paper Form CMS-855 change request, the contractor may accept the signature of a delegated official in Section 15 or 16 of the Form CMS-855.

12. Certification Statement Development – When the contractor develops for missing or additional information and the provider must submit a newly-signed certification statement, only the actual signature page is required; the additional page containing the certification terms need not be submitted unless the contractor requests it. This does not apply, however, to the provider's initial submission of a certification

statement for a particular application; such instances require the submission of both the signature page and the page containing the certification terms. To illustrate, suppose the provider submits an initial CMS-855 application with an undated certification statement. The provider must furnish a newly-dated (and signed) certification statement and the certification terms page; it does so on March 1. On March 15, the contractor determines that information on section 4 of the provider's application is incorrect and must be revised. When submitting the revised section 4 page, the provider need only furnish a newly-signed signature page; the certification terms page need not be submitted unless the contractor requests it.

15.5.20 – Processing Form CMS-855R Applications

(Rev. 636, Issued: 02-04-16, Effective: 03-04-16- Implementation: 03-04-16)

A. General Information

A Form CMS-855R application must be completed for any individual who will: (1) reassign his/her benefits to an eligible entity, or (2) terminate an existing reassignment.

If the individual who wants to reassign his or her benefits is not enrolled in Medicare, the person must complete a Form CMS-855I as well as a Form CMS-855R. (The CMS-855I and CMS-855R can be submitted concurrently.) Moreover, if the entity to which the person's benefits will be reassigned is not enrolled in Medicare, the organization must complete a Form CMS-855B or, if applicable, a Form CMS-855A. (See section 15.7.6 for additional instructions regarding the joint processing of Form CMS-855As, Form CMS-855Rs, Form CMS-855Bs, and Form CMS-855Is.)

Benefits are reassigned to a provider or supplier, not to the practice location(s) of the provider or supplier. As such, the contractor shall not require each practitioner in a group to submit a Form CMS-855R each time the group adds a practice location.

An individual can receive reassigned benefits. The most common example of this is a physician or practitioner who reassigns his/her benefits to a physician who is either (1) a sole proprietor, or (2) the sole owner of an entity listed in section 4A of the Form CMS-855I. Here, the only forms that are necessary are the Form CMS-855R and separate Form CMS-855Is from the reassignor and the reassignee. (No Form CMS-855B or Form CMS-855A is involved.) The reassignee himself/herself must sign section 4B of the Form CMS-855R, as there is no authorized or delegated official involved.

The contractor shall follow the instructions in Pub. 100-04, Chapter 1, sections 30.2 – 30.2.16 to ensure that a physician or other provider or supplier is eligible to receive reassigned benefits.

B. Reassignment to Entities that Complete the Form CMS-855A

Consistent with 42 CFR § 424.80(b)(1) and (b)(2) and Pub. 100-04, Chapter 1, sections 30.2.1(D) and (E) and 30.2.6 and 30.2.7 - Medicare may pay: (1) a physician or other provider or supplier's employer if the provider or supplier is required, as a condition of employment, to turn over to the employer the fees for his or her services; or (2) an entity (i.e., a person, group, or facility) that is enrolled in the Medicare program for services furnished by a physician or other provider or supplier under a contractual arrangement with that entity. This means that Part A and Part B entities other than physician/practitioner group practices can receive reassigned benefits, assuming the requirements for a reassignment exception are met. For example, on the Part A side, this might occur with (1) a physician or other provider or supplier reassigning benefits to a hospital, skilled nursing facility, or critical access hospital billing under Method II (CAH II) or (2) a nurse practitioner reassigning to a CAH II.

If the entity receiving the reassigned benefits is not a CAH II, it must enroll with the contractor via a Form CMS-855B, and the physician/practitioner reassigning benefits must complete and submit a Form CMS-855I and Form CMS-855R.

If the entity receiving the reassigned benefits is a CAH II, the entity need not and should not complete a separate Form CMS-855B form to receive reassigned benefits. The physician/practitioner can reassign benefits directly to the CAH II's, Part A enrollment. The distinction between CAHs billing Method I vs. Method II only applies to outpatient services; it does not apply to inpatient services.

Under Method I:

- The CAH bills for facility services
- The physicians/practitioners bill separately for their professional services

Under Method II:

- The CAH bills for facility services
- If a physician/practitioner has reassigned his/her benefits to the CAH, the CAH bills for that particular physician's/practitioner's professional service
- If a CAH has elected Method II, the physician/practitioner is not required to reassign his or her benefits to the CAH. For those physicians/practitioners who do not reassign their benefits to the CAH, the CAH only bills for facility services and the physicians/practitioners separately bill for their professional services (similar to Method I).

Although physicians or non-physician practitioners are not required to reassign their benefits to a CAH that bills Method II, doing so allows them to participate in the Electronic Health Records (EHR) Incentive Program for Eligible Professionals (EPs).

In this scenario the CMS-855I and CMS-855R shall be submitted to the Part B MAC and the CMS-855A submitted to the Part A MAC. The Part B MAC shall be responsible for reassigning the individual to the Part A entity.

The reassignment to the Part A entity shall only occur if the CMS-855A for the CAH II has been finalized. This can be determined by viewing PECOS to identify if an approved enrollment exists for the CAH II. If one does not, the Part B MAC shall return the CMS-855I and/or CMS-855R to the provider. If an enrollment record exist but is in an Approved Pending RO Review status, the Part B MAC shall contact the Part A MAC to determine if the Tie-In has been received from the RO but not yet updated in PECOS, prior to returning the applications.

C. Ambulatory Surgical Centers (ASCs) and Reassignment

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

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

D. Reassignment and Revoked/Deceased Physicians and Non-Physician Practitioners

There are situations where a physician/non-physician practitioner (the "owning physician/practitioner") owns 100% of his/her own practice, employs another physician (the "employed physician/practitioner") to work with him/her, and accepts reassigned benefits from the employed physician/practitioner. Should the sole proprietor or sole owner die or have his/her billing privileges revoked, the practice is automatically dissolved for purposes of Medicare enrollment and all reassignments to the practice are automatically terminated as well. Neither the owning physician/practitioner nor the practice is enrolled in Medicare any longer and the billing privileges for both shall be revoked in accordance with the revocation procedures

outlined in this chapter. (It is immaterial whether the practice was established as a sole proprietorship, a PC, a PA, or a solely-owned LLC.) In addition, the contractor shall end-date the reassignment using, as applicable, the date of death or the effective date of the revocation.

Besides revoking the billing privileges of the owning physician/practitioner and the practice, the contractor shall notify the employed physician/practitioner that:

(1) The practice's billing privileges have been revoked;

(2) Any services furnished by him/her on behalf of the practice after the date of the owning physician/practitioner's death will not be paid; and

(3) If the employed physician/practitioner wishes to provide services at the former practice's location, he/she must submit via Internet-based PECOS (or a paper CMS-855 application) a CMS-855I change of information request to add the owning physician/practitioner's practice location as a new location of the employed physician/practitioner. For purposes of this section 15.5.20(C)(3) only, submission of a (1) complete CMS-855I application as an initial enrollment and (2) a terminating CMS-855R application are not required – even if the employed physician/non-physician practitioner had reassigned all of his/her benefits to the practice.

E. Miscellaneous Reassignment Policies

1. If the individual is initiating a reassignment, both he/she and the group's authorized or delegated official must sign section *6* of the Form CMS-855R. If either of the two signatures is missing, the contractor shall develop for it.

2. If the person (or group) is terminating a reassignment, either party may sign section *6* of the Form CMS-855R; obtaining both signatures is not required. If no signatures are present, the contractor shall develop for a signature.

3. A Form CMS-855R is required to terminate a reassignment. The termination cannot be done via the Form CMS-855I.

4. The authorized or delegated official who signs section *6* of the Form CMS-855R must be currently on file with the contractor as such. If this is a new enrollment - with a joint submission of the Form(s) CMS-855A or CMS 855B, Form CMS-855I, and Form CMS-855R, the person must be listed on the CMS-855A or CMS-855B as an authorized or delegated official.

5. *If the reassignor currently has an active Form CMS-855I on file and is only submitting a Form CMS-855R to establish a new reassignment, the effective date shall be the date the practitioner began or will begin rendering services with the reassignee. If the Form CMS-855R is accompanied by a Form CMS-855I, the effective date of the enrollment and the reassignment shall be consistent with the 30-day rule (i.e., the later of the date of filing or the date the reassignor first began furnishing services at the new location) specified in section 15.17 of this chapter.*

6. The contractor need not verify whether the reassigning individual is a W-2 employee or a 1099 contractor.

7. There may be situations where a Form CMS-855R is submitted and the reassignee is already enrolled in Medicare via the Form CMS-855B. However, the authorized official is not on file. In this case, the contractor shall develop for a Form(s) CMS-855A or CMS-855B change request that adds the new authorized official.

8. In situations where the provider or supplier is both adding and terminating a reassignment, each transaction must be reported on a separate Form CMS-855R. The same Form CMS-855R cannot be used for both transactions.

9. The Form CMS-855R application shall not be used to:

- *Report employment arrangements of physician assistants (PA); employment arrangements for PAs must be reported on the Form CMS-855I.*

- *Revalidate reassignments; the individual practitioner should only use the Form CMS-855I application for revalidations and list his/her active reassignment information in section 4B thereof.*

15.5.20.1 – Inter-Jurisdictional Reassignments

(Rev. 636, Issued: 02-04-16, Effective: 03-04-16- Implementation: 03-04-16)

A. General Policy

If a physician/NPP (reassignor) is reassigning his or her benefits to an entity (reassignee) located in another contractor jurisdiction – a practice that is permissible - the following principles apply:

1. The reassignor must be properly licensed or otherwise authorized to perform services in the state in which he or she has his or her practice location. The practice location can be an office or even the individual's home (for example, a physician interprets test results in his home for an independent diagnostic testing facility).

2. The reassignor need not – pursuant to the reassignment - enroll in the reassignee's contractor jurisdiction nor be licensed/authorized to practice in the reassignee's state. If the reassignor will be performing services within the reassignee's state, the reassignor must enroll with the Medicare contractor for – and be licensed/authorized to practice in – that state.

3. The reassignee must enroll in the contractor jurisdictions in which (1) it has its own practice location(s), and (2) the reassignor has his or her practice location(s). In Case (2), the reassignee:

- Shall identify the reassignor's practice location as its practice location on its Form CMS-855B

- In Section 4A of its Form CMS-855B shall select the practice location type as "Other health care facility" and specify "Telemedicine location."

- Need not be licensed/authorized to perform services in the reassignor's state.

To illustrate, suppose Dr. Smith is located in Contractor Jurisdiction X and is reassigning his benefits to Jones Medical Group in Contractor Jurisdiction Y. Jones must enroll with X and with Y. Jones need not be licensed/authorized to perform services in Dr. Smith's state. However, in Section 4 of the Form CMS- 855B it submits to X, Jones must list Dr. Smith's location as its practice location.

B. Applicability

The term "reassignee," as used in section 15.5.20.1(A), includes any provider or supplier that is permitted to bill and receive payment under a reassignment, in accordance with existing Medicare policy.

15.6.1.1.1 – Form *CMS-855* Applications That Require *a* Site Visit

(Rev. 636, Issued: 02-04-16, Effective: 03-04-16- Implementation: 03-04-16)

The contractor shall process 80 percent of all Form CMS-855 initial applications that require a site visit within 80 calendar days of receipt, process 90 percent of all Form CMS-855 initial applications that require a site visit within 150 calendar days of receipt, and process 95 percent of all Form CMS-855 initial applications that require a site visit within 210 calendar days of receipt.

15.6.1.1.2 – Form *CMS-855* Applications That Do Not Require *a* Site Visit

(Rev. 636, Issued: 02-04-16, Effective: 03-04-16- Implementation: 03-04-16)

The contractor shall process 80 percent of all Form CMS-855 initial applications that do not require a site visit within 60 calendar days of receipt, process 90 percent of all Form CMS-855 initial applications that do not require a site visit within 120 calendar days of receipt, and process 95 percent of all Form CMS-855 initial applications that do not require a site visit within 180 calendar days of receipt.

15.6.3 - General Timeliness Principles

(Rev. 636, Issued: 02-04-16, Effective: 03-04-16- Implementation: 03-04-16)

Unless stated otherwise in this chapter or in another CMS directive, the principles discussed below apply to all applications discussed in sections 15.6.1 through 15.6.2.3 of this chapter (e.g., change of ownership (CHOW) applications submitted by old and new owners, CMS-588 forms).

A. Clock Stoppages

The processing time clocks identified in sections 15.6.1 and 15.6.2.3 of this chapter cannot be stopped or suspended for any reason. This includes, but is not limited to, the following situations:

- Referring an application to the Office of Inspector General (OIG) or the Zone Program Integrity Contractor.
- Waiting for a final sales agreement (e.g., CHOW, acquisition/merger).
- Waiting for the regional office (RO) to make a provider-based or CHOW determination.
- Referring a provider to the Social Security Administration to resolve a discrepancy involving a social security number.
- Contacting *CMS'* Provider Enrollment *& Oversight* Group (PEOG) or an RO's survey/certification staff with a question regarding the application or CMS policy.

Notwithstanding the prohibition on clock stoppages and suspensions, the contractor should always document any delays by identifying when the referral to CMS, the OIG, etc., was made, the reason for the referral, and when a response was received. By doing so, the contractor will be able to furnish explanatory documentation to CMS should applicable time limits be exceeded. To illustrate, assume that a contractor received an initial Form CMS-855I application on March 1. On March 30, the contractor sent a question to CMS, and received a reply on April 7. The processing time clock did not stop from March 31 to April 7. However, the contractor should document its files to explain that it forwarded the question to CMS, the dates involved, and the reason for the referral.

B. Calendar Days

Unless otherwise stated in this chapter, all days in the processing time clock are "calendar" days, not "business days." If the 60th day (for initials) or 45th day (for changes of information) falls on a weekend or holiday, this is still the day by which the application must be processed. If the contractor is unable to finish processing the application until the next business day, it should document the file that the 60th day fell on a Saturday/Sunday/holiday and furnish any additional explanation as needed.

C. Date-Stamping

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

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

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

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

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

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

In addition, and unless stated otherwise in this chapter or in another CMS directive, all incoming enrollment applications (including change requests) must be submitted via mail.

D. When the Processing Cycle Ends

For (1) Form CMS-855A applications, and (2) Form CMS-855B applications submitted by ambulatory surgical centers (ASCs) or portable x-ray suppliers, the processing cycle ends on the date that the contractor:

- Sends its recommendation of approval to the State agency

- Denies the application

In situations involving a change request that does not require a recommendation (i.e., it need not be forwarded to and approved by the State or RO), the cycle ends on the date that the contractor sends notification to the provider that the change has been processed. If notification to the provider is made via telephone, the cycle ends on the date that the telephone call is made (e.g., the date the voice mail message is left).

For (1) Form CMS-855I applications, (2) Form CMS-855R applications, and (3) Form CMS-855B applications from suppliers other than ASCs and portable x-ray suppliers, the processing cycle ends on the

date that the contractor sends its approval/denial letter to the supplier. For change request approval/denial notifications made via telephone, the cycle ends on the date that the telephone call is made (e.g., the date the voice mail message is left).

For any application that is rejected per existing instructions, the processing time clock ends on the date that the contractor sends notification to the provider that the application has been rejected.

E. PECOS

Unless stated otherwise in this chapter or in another CMS directive, the contractor must create a logging & tracking (L & T) record in PECOS:

- For applications that do not require an application fee, no later than 20 calendar days after its receipt of the provider's application in the contractor's mailroom.

- For applications that require an application fee, no later than 20 calendar days after:

    - The date on which the provider paid the fee – as confirmed by either the Fee Submitter List or the provider's submission of a receipt of payment from Pay.gov, or

    - The date on which PEOG approved the provider's hardship exception request (or, for suppliers of durable medical requirement, prosthetics, orthotics and supplies, the date on which the NSC approved the hardship exception request).

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

The L & T and enrollment record requirements in the previous paragraph apply to all applications identified in sections 15.6.1 through 15.6.2.4 of this chapter (e.g., reassignments, CHOW applications submitted by old and new owners).

In situations where the contractor cannot create an L & T record within 20 days due to missing information (e.g., no NPI was furnished), the contractor shall document the provider file accordingly.

15.7.1.2 – Receipt/Review of Internet-Based PECOS Applications

(Rev. 636, Issued: 02-04-16, Effective: 03-04-16- Implementation: 03-04-16)

A. Submission of Paper Certification Statement

1. Background and Timeframe

If the provider chooses to submit its certification statement via paper rather than through e-signature, it may do so by mail, fax, or scanned e-mail. Unless stated otherwise in this chapter or in another CMS directive:

- The provider must submit the certification statement within 45 calendar days of the date on which it submitted its Internet-based PECOS application. (This applies to all Form CMS-855 Internet-based PECOS submissions, regardless of the type of transaction involved.)

- If the contractor does not receive the certification statement in its mailroom (or via fax/email) within the 45-day period, the contractor may either return the application (unless another CMS directive states otherwise) or contact the provider via any means to request the certification statement. If the contractor chooses the latter option, it shall inform the provider (1) of the deadline by which the statement must be received and (2) that the provider may still sign the application via e-signature. (The specific deadline in (1) lies within the contractor's discretion.)

- If the provider submits an invalid certification statement (e.g., undated; incorrect individual signed it; not all authorized officials signed it), the contractor shall treat this as missing information and shall develop for a correct certification statement using – unless another CMS directive states otherwise - the procedures outlined in this chapter.

- *If the provider wishes to submit a paper CMS-855 certification statement (downloaded from www.cms.gov), it should write the tracking ID on the top of the certification statement.*

2. Switch to "In Review" and Application Returns

After – and only after – the contractor receives the provider's certification statement and application fee (if applicable), the contractor shall: (1) enter the date of signature in the "Certification Date" box in the logging & tracking (L & T) record, and (2) change the L & T status to "In Review." The contractor shall not begin processing the application prior to its receipt of the certification statement and its completion of tasks (1) and (2) in the previous sentence.

If the provider submitted an invalid certification statement, the contractor shall still complete tasks (1) and (2) above. (If the certification statement was undated, the contractor shall use the date that the 45-day clock expired as the date of signature.) An appropriate certification statement can be solicited as part of the development process.

If the contractor can determine (without having yet begun processing the application) that an application can be returned under section 15.8.1 of this chapter (e.g., Form CMS-855I was submitted more than 60 days prior to the effective date), the contractor may return the application without waiting for the arrival of the certification statement.

B. Processing of Application

After tasks (1) and (2) above have been completed, the contractor shall begin processing the application. Subject to the processing alternatives in sections 15.7.1.3.1 through 15.7.1.3.4, processing includes (but is not limited to):

- Ensuring that all required data elements on the application have been completed and that all required supporting documentation has been submitted (either via paper or the Digital Data Repository (DDR))

- Validating all data on and submitted with the application

15.7.1.3 – Verification of Data/Processing Alternatives

(Rev. 636, Issued: 02-04-16, Effective: 03-04-16- Implementation: 03-04-16)

A. Verification - General

1. Means of Verification

Unless stated otherwise in this chapter or in another CMS directive, the contractor shall verify and validate – via the most cost-effective methods available - all information furnished by the provider on or with its application. The general purpose of the verification process is to ensure that all of the data furnished on the Form CMS-855 is accurate.

Examples of verification techniques include, but are not limited to:

- Site visits

- Third-party data validation sources

- State professional licensure and certification Web sites (e.g., medical board sites)

- Federal licensure and certification Web sites (if applicable)

- State business Web sites (e.g., to validate "doing business as" name)

- Yellow Pages (e.g., to verify certain phone numbers)

The list of verification techniques identified in this section 15.7.1.3 is not exhaustive. If the contractor is aware of another means of validation that is as cost-effective and accurate as those listed, it is free to use such means. However, all Social Security Numbers (SSNs) and National Provider Identifiers (NPIs) listed on the application will continue to be verified through PECOS.
The contractor shall not request an SSN card to verify an individual's identity or SSN.

2. Procedures

Unless stated otherwise in this chapter or in another CMS directive, the following principles apply:

(1) A data element is considered "verified" when, after attempting at least one means of validation, the contractor is confident that the data is accurate. (The contractor shall use its best judgment when making this assessment.)

(2) The contractor need only make one verification attempt (i.e., need only use one validation technique) before either:

(a) Requesting clarifying information (as described in sections 15.7.1.4 through 15.7.1.6.2) if the data element cannot be verified. (However, the contractor is encouraged to make a second attempt using a different validation means prior to requesting clarification.)

OR

(b) Concluding that the furnished data is accurate.

3. Concurrent Reviews

If the contractor receives multiple Form CMS-855s for related entities, it can perform concurrent reviews of similar data. For instance, suppose a chain home office submits initial Form CMS-855As for four of its chain providers. The ownership information (sections 5 and 6) and chain home office data (section 7) is the same for all four providers. The contractor need only verify the ownership and home office data once; it need not do it four times – once for each provider. However, the contractor shall document in each provider's file that a single verification check was made for all four applications.

For purposes of this requirement: (1) there must be an organizational, employment, or other business relationship between the entities, and (2) the applications must have been submitted within a few weeks of each other. As an illustration, assume that Group Practice A submits an initial Form CMS-855B on January 1. Group Practice B submits one on October 1. Section 6 indicates that Joe Smith is a co-owner of both practices, though both entities have many other owners that are not similar. In this case, the contractor must verify Mr. Smith's data in both January and October. It cannot use the January verification and apply it to Group B's application because: (1) the applications were submitted nine months apart, and (2) there is no evidence that the entities are related.

4. Contacting Other Contractor

During the verification process, the contractor may need to contact another Medicare contractor for information regarding the provider. The latter contractor shall respond to the former contractor's request within three business days absent extenuating circumstances.

B. Processing Alternatives

Sections 15.7.1.3.1 through 15.7.1.3.4 outline special processing rules ("processing alternatives") that are intended to reduce the burden on contractors and providers while simultaneously maintaining the integrity of the enrollment process. These provisions take precedence over all other instructions outlined in this chapter 15.

15.7.5 – Special Program Integrity Procedures

(Rev. 636, Issued: 02-04-16, Effective: 03-04-16- Implementation: 03-04-16)

This section contains additional verification procedures that the contractor shall utilize when processing the following transactions:

- Changes in the provider's practice location
- Changes in the provider's correspondence or special payment address
- On the Form CMS-588, changes in the provider's bank name, depository routing transit number, or depository account number
- Revalidations and Form CMS-855 Reactivations

The instructions in this section 15.7.5 are in addition to, and not in lieu of, all other verification instructions contained in this chapter and in other CMS directives. Also, unless otherwise stated, section 15.7.5 applies to the Form CMS-855A, Form CMS-855B and Form CMS-855I.

The signature comparison requirements stated below are not necessary if the Form CMS-855 or Form CMS-588 change request, reactivation, or revalidation was submitted with an electronic signature.

A. Change in Practice Location Address

In cases where a provider submits a Form CMS-855 request to change its practice location address, the contractor shall undertake the following activities:

1. Contact the location currently associated with the provider in the Provider Enrollment, Chain and Ownership System (PECOS) or the Multi-Carrier System (MCS) to verify that the provider is no longer there and did in fact move.

2. Request that the provider fax to the contractor a copy of a phone bill/power bill or other documentation containing the business's new legal business name (LBN) or doing business as (DBA) name and its new address.

B. Change in Correspondence or Special Payments Address

If the provider submits a change to its correspondence or special payments address, the contractor shall contact the individual physician/practitioner (for Form CMS-855I changes), an authorized or delegated official (for Form CMS-855A and Form CMS-855B changes), or the contact person listed in section 13 (for Form CMS-855A, Form CMS-855B, and Form CMS-855I changes) to verify the change. Hence, if the contractor cannot reach, as applicable, the individual physician/practitioner or an authorized or delegated official, it shall confirm the change with the contact person.

C. Change of EFT Information

If the provider submits a Form CMS-588 request to change the bank name, depository routing transit number, or depository account number, the contractor shall contact the individual physician/practitioner (for Form CMS-855I enrollees), an authorized or delegated official on record (for Form CMS-855A and Form CMS-855B enrollees), or the section 13 contact person on record (for Form CMS-855A, Form CMS-855B, and Form CMS-855I enrollees) to verify the change. Hence, if the contractor cannot reach, as applicable,

the individual physician/practitioner or an authorized or delegated official, it shall confirm the change with the contact person.

D. Revalidations and Form CMS-855 Reactivations

When processing a revalidation or Form CMS-855 reactivation application, the contractor shall – unless another CMS directive instructs otherwise - the contractor shall abide by the instructions in subsections A and B above, respectively, if the (a) practice location address or (b) correspondence/special payment address on the application is different than that which is currently associated with the provider in PECOS or MCS.

E. Reassignment of All Benefits

If a physician or non-physician practitioner who is currently reassigning all of his or her benefits attempts to enroll as a sole proprietorship or the sole owner of his or her professional corporation, professional association, or limited liability company, the contractor shall call the old practice location to determine if the physician or non-physician practitioner is still employed there; if he or she is not, contact the practitioner to verify that he or she is indeed attempting to enroll as a sole proprietorship or sole owner. *(A copy of his/her driver's license should not be requested.)*

F. Potential Identity Theft or Other Fraudulent Activity

In conducting the verification activities described in this section 15.7.5, if the contractor believes that a case of identity theft or other fraudulent activity likely exists (e.g., physician or practitioner indicates that he or she is not establishing a new practice location or changing his or her EFT information, and that the application submitted in his/her name is false), the contractor shall notify its CMS Provider Enrollment *& Oversight Group* Business Function Lead *(PEOG BFL)* immediately; *the BFL will instruct the contractor as to what, if any, action shall be taken.*

15.7.7.2 - Tie-In/Tie-Out Notices and Referrals to the State/RO

(Rev. 636, Issued: 02-04-16, Effective: 03-04-16- Implementation: 03-04-16)

A. Issuance of Tie-In/Tie-Out Notices

A tie-in or tie-out notice (CMS-2007) is generally issued in the following circumstances:

1. Initial enrollments

2. CHOWs

3. Voluntary terminations

4. Involuntary terminations (e.g., provider no longer meets conditions of participation or coverage) prompted by the *s*tate/RO

With the exception of voluntary and involuntary terminations, each of the transactions described above requires a referral and recommendation to the *s*tate/RO.

(Depending on the specific RO, certain changes of information may also result in the issuance of a CMS-2007.)

B. Form CMS-855 Changes of Information, Stock Transfers, and Other Transactions

1. Referrals to State/RO

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

- Addition of outpatient physician therapy/outpatient speech pathology extension site
- Addition of hospice satellite
- Addition of home health agency branch
- Change in type of Prospective Payment System (PPS)-exempt unit
- Conversion of a hospital from one type to another (e.g., acute care to psychiatric)
- Change in practice location or subunit address in cases where a survey of the new site is required
- Stock transfer

In these situations, the Provider Enrollment, Chain and Ownership System (PECOS) record should not be switched to "approved" until the contractor receives notice from the RO that the latter has authorized the transaction. However, if the contractor knows that the particular state/RO in question typically does not review, approve, or deny this type of transaction, the contractor need not send the transaction to the state/RO for approval and shall instead follow the instructions in (B)(2) below.

(If the transaction is a stock transfer, the contractor need not send the transaction to the state/RO for approval (and shall instead follow the instructions in (B)(2) below) if the following three conditions are met:

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

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

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

If any of these 3 conditions are not met, the contractor shall send the transaction to the state/RO for approval.)

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

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

2. Post-Approval RO Contact Required

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

- Deletions/voluntary terminations of practice locations or hospital subunits

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

- Address changes that do not require a survey of the new location

- Addition of hospital practice location

- The transactions (excluding stock transfers) described in (B)(1) for which the contractor knows that the state/RO does not issue approvals/denials

- Stock transfers for which the 3 conditions mentioned in (B)(1) are met.

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

3. All Other Changes of Information

For all Form CMS-855A change requests not identified in (B)(1) or (B)(2) above, the contractor shall notify the provider via letter, fax, e-mail, or telephone that the change has been made and shall switch the PECOS record to "approved." The state and RO need not be notified of the change.

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

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

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

C. Provider-Specific, Non-CMS-855 Changes

If the contractor receives a tie-in notice or approval letter from the RO for a transaction/change regarding information that is not collected on the Form CMS-855A, the contractor need not ask the provider to submit a Form CMS-855A change of information.

D. Involuntary Termination Prompted by State/RO

If the contractor receives a tie-out notice from the RO that involuntarily terminates the provider's Medicare participation because the provider no longer meets the conditions of participation, the contractor need not send a letter to the provider notifying it that its Medicare participation/enrollment has been terminated. (The

RO will issue such a letter and afford appeal rights.) *The contractor shall adhere to the instructions in section 15.27.2 of this chapter with respect to revoking the provider's/supplier's enrollment.*

E. Other Procedures Related to Tie-In Notices, Tie-Out Notices and Approval Letters

1. Receipt of Tie-In When Form CMS-855A Not Completed - If the contractor receives a tie-in notice or approval letter from the RO but the provider never completed the necessary Form CMS-855A, the contractor shall have the provider complete and submit said form. This applies to initial applications, CHOWs, practice location additions, etc., but does not apply to the cases described in subsection C above.

2. Delegation to State Agency – There may be instances when the RO delegates the task of issuing tie-in notices, tie-out notices or approval letters to the state agency. The contractor may accept such notices from the state in lieu of those from the RO. However, the contractor should first contact the applicable RO to confirm: (1) that the RO has delegated this function to the state, and (2) the specific transactions (e.g., CHOWs, HHA branch additions) for which this function has been delegated.

3. Review for Consistency - When the contractor receives a tie-in notice or approval letter from the RO, it shall review its contents to ensure that the data on the notice/letter matches that on the Form CMS-855A. If there are discrepancies (e.g., different legal business name, address), the contractor shall contact the applicable RO to determine why the data is different.

4. Creation of New Logging and Tracking (L & T) Record Unnecessary - The contractor is not required to create a new L & T record in PECOS when the tie-in notice arrives, as the existing record should not be in a final status and can therefore be modified. Simply changing the L & T status is sufficient.

5. Provider Inquiries – Once the contractor has made its recommendation for approval to the state/RO, any inquiry the contractor receives from the provider regarding the status of its request for Medicare participation shall be referred to the state or RO.

6. Timeframes - So as not to keep the PECOS record in "approval recommended" status interminably, if the contractor does not receive notification of approval from the RO after what it deems to be an excessive amount of time, it may contact the RO to see if such approval is forthcoming.

15.7.8.4 - Ambulatory Surgical Centers (ASCs)/Portable X-ray Suppliers (PXRS) Tie-In/Tie-Out Notices and Referrals to the State/RO

(Rev. 636, Issued: 02-04-16, Effective: 03-04-16- Implementation: 03-04-16)

(For purposes of this section 15.7.8.4, the terms "tie-in notices" and approval letters will be collectively referred to as tie-in notices. "Tie-out notices" are notices from the RO to the contractor that, in effect, state that the ASC's/PXRS's participation in Medicare should be terminated.)

A. Issuance of Tie-In/Tie-Out Notices

A tie-in or tie-out notice is generally issued in the following circumstances:

1. Initial enrollments

2. CHOWs

3. Voluntary terminations

4. Involuntary terminations (e.g., supplier no longer meets conditions of coverage) prompted by the state/RO.

With the exception of voluntary and involuntary terminations, each of the transactions described above requires a referral and recommendation to the state/RO.

(Depending on the specific RO, certain changes of information may also result in the issuance of a CMS-2007.)

B. Form CMS-855B Changes of Information, Stock Transfers, and Other Transactions

1. Referrals to State/RO

The following is a list of transactions that require a recommendation and referral to the state/RO:

- Addition of practice location
- Stock transfer
- Change in practice location or address in cases where a survey of the new site is required

In these situations, the Provider Enrollment, Chain and Ownership System (PECOS) record should not be switched to "approved" until the contractor receives notice from the RO that the latter has authorized the transaction. However, if the contractor knows that the particular state/RO in question typically does not review, approve, or deny this type of transaction, the contractor need not send the transaction to the state/RO for approval and shall instead follow the instructions in (B)(2) below.

(If the transaction is a stock transfer, the contractor need not send the transaction to the state/RO for approval (and shall instead follow the instructions in (B)(2) below) if the following three conditions are met:

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

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

(3) The contractor knows that the particular state/RO in question does not review, approve, or deny this

type of transaction.

If any of these 3 conditions are not met, the contractor shall send the transaction to the state/RO for approval.)

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

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

2. Post-Approval RO Contact Required

Changes that do not mandate a recommendation to the state/RO but do require post-approval correspondence with the RO include:

- Deletions/voluntary terminations of practice locations or subunits
- Legal business name, tax identification number or "doing business as" name changes that do not involve a CHOW
- Address changes that do not require a survey of the new location
- The transactions (excluding stock transfers) described in (B)(1) for which the contractor knows that the state/RO does not issue approvals/denials
- Stock transfers for which the 3 conditions mentioned in (B)(1) are met.

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

3. All Other Changes of Information

For all Form CMS-855B change requests not identified in (B)(1) or (B)(2) above, the contractor shall notify the supplier via letter, fax, e-mail, or telephone that the change has been made and shall switch the PECOS record to "approved." The state and RO need not be notified of the change.

4. Revalidations, Reactivations and Complete CMS-855 Applications

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

If the application contains changed data falling within one of the categories in (B)(2) above, the contractor can switch the PECOS record to "approved." The contractor shall also notify the state and RO of the

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

C. Supplier-Specific, Non-CMS-855 Changes

If the contractor receives a tie-in notice or approval letter for a transaction that concerns information not collected on the Form CMS-855B application, the contractor need not ask the supplier to submit a Form CMS-855B change of information.

D. Involuntary Termination Prompted by State/RO

If the contractor receives a tie-out notice from the RO that involuntarily terminates the supplier's Medicare participation because the supplier no longer meets the conditions of coverage, the contractor need not send a letter to the supplier notifying it that its Medicare participation/enrollment has been terminated. The RO will issue such a letter and afford appeal rights.

The contractor shall adhere to the instructions in section 15.27.2 of this chapter with respect to revoking the supplier's enrollment.

E. Other Procedures Related to Tie-In/Tie-Out Notices and Approval Letters

1. Receipt of Tie-In When Form CMS-855B Not Completed

If the contractor receives a tie-in notice or approval letter from the RO but the supplier never completed the necessary Form CMS-855B, the contractor shall have the supplier complete and submit said form. This applies to initial applications, CHOWs, practice location additions, etc., but does not apply to the cases described in subsection C above.

2. Delegation to State Agency

There may be instances when the RO delegates the task of issuing tie-in/tie-out notices or approval letters to the state agency. The contractor may accept such notices from the state in lieu of those from the RO. However, the contractor should first contact the applicable RO to confirm: (1) that the RO has delegated this function to the state, and (2) the specific transactions (e.g., CHOWs, site additions) for which this function has been delegated.

3. Review for Consistency

When the contractor receives a tie-in notice or approval letter from the RO, it shall review its contents to ensure that the data on the notice/letter matches that on the Form CMS-855B. If there are discrepancies (e.g., different legal business name, address), the contractor shall contact the applicable RO to determine why the data is different.

4. Creation of New Logging and Tracking (L & T) Record Unnecessary

The contractor is not required to create a new L & T record in PECOS when the tie-in notice or approval letter arrives, as the existing record should not be in a final status and can therefore be modified. Simply changing the L & T status is sufficient.

5. Supplier Inquiries

Once the contractor makes its recommendation for approval to the *s*tate/RO, any inquiry the contractor receives from the supplier regarding the status of its request for Medicare participation shall be referred to the *s*tate or RO.

6. Timeframes

So as not to keep the PECOS record in "approval recommended" status interminably, if the contractor does not receive notification of approval from the RO after what it deems to be an excessive amount of time, it may contact the RO to see if such approval is forthcoming.

15.7.9.3 – Processing of Registration Applications

(Rev. 636, Issued: 02-04-16, Effective: 03-04-16- Implementation: 03-04-16)

A. Basic Requirements

Upon receipt of a Form CMS-855C registration application from an IPP entity, the contractor shall begin processing the application. This includes:

- Ensuring that the application is complete (see section D(1) below for additional information).

- Creating a logging & tracking (L & T) record and entering the IPP entity's information in the Provider Enrollment, Chain and Ownership System (PECOS).

- Verifying the information on the application in accordance with (1) the "limited" category of screening (see section 15.19.2.1(A) of this chapter for more information), and (2) existing processing guidelines (e.g., reviewing all entities and individuals listed on the Form CMS-855 against the Medicare Exclusion Database and *SAM*.

- Ensuring that the attestation identified in section 15.7.9.2 above is submitted, signed by an authorized official, and contains the required language.

- As needed, asking the entity for additional or clarifying information using the procedures outlined in this chapter and other applicable CMS directives; this may include information – beyond the attestation itself – that is necessary to determine whether the entity is indeed in compliance with the provisions of 42 CFR §424.66.

- Assigning specialty code C2.

- Assigning a Provider Transaction Access Number (PTAN) (if the application is approved).

B. Prescreening

The contractor need not "prescreen" (as that term is described in section 15.7.1.1 of this chapter) the registration application.

C. Returns

Section 15.8.1 of this chapter outlines the reasons for which the contractor may immediately return a Form CMS-855C. If the contractor determines that one or more of these reasons applies, it shall return the registration application in accordance with the instructions outlined in that section.

D. Development Issues

If, in response to a development request, the IPP entity indicates that it is unable to furnish certain data elements because said elements do not apply to it, the contractor shall contact its *CMS* Provider Enrollment *& Oversight* Group Business Function Lead (PEOG BFL) for guidance.

E. Timeliness and Accuracy Standards

The timeliness and accuracy standards in sections 15.6.1.1.3, 15.6.1.2, 15.6.2.1, and 15.6.2.2 of this chapter apply to the processing of IPP initial applications and changes of information. Should the contractor exceed timeliness standards due to the requirements of sections 15.7.9.1 through 15.7.9.7, the contractor shall note the provider file in accordance with section 15.7.3 of this chapter.

F. HPID/OEID

The algorithm for the HPID/OEID is similar to that of the National Provider Identifier in that it will be 10 digits in length and will begin with either a "7" (HPID) or a "6" (OEID). The HPID/OEID will replace the placeholder NPI for IPP entities only.

15.7.9.4 – Disposition of Registration Applications

(Rev. 636, Issued: 02-04-16, Effective: 03-04-16- Implementation: 03-04-16)

A. Approval

If the contractor determines that the IPP entity meets all necessary requirements, it shall send an e-mail to its *CMS* Provider Enrollment *& Oversight* Group Business Function Lead (PEOG BFL) that contains: (1) the entity's legal business name, "doing business as" name (if applicable) and HPID or OEID; (2) a draft approval letter patterned after the applicable model letter in section 15.7.9.7; and (3) any issues the contractor encountered in its review. The PEOG BFL will review the matter and advise the contractor as to how to proceed.

If PEOG authorizes the approval, the contractor shall (1) switch the Provider Enrollment, Chain and Ownership System (PECOS) record to "Approved," (2) establish an effective date that is the date on which the contractor approved the application, (3) assign a Provider Transaction Access Number (PTAN) or National Supplier Clearinghouse number (as applicable), and (4) send the approval letter via regular mail or e-mail to the entity no later than *3* business days after the contractor received authorization of the approval from PEOG.

After the entity is registered, the contractor (consistent with § 424.66(a)(5)) may request additional information in order to confirm the entity's continued compliance with 42 CFR § 424.66.

B. Denial

If the contractor determines that the entity does not meet all necessary requirements, it shall send an e-mail to its PEOG BFL that contains: (1) the entity's legal business name, "doing business as" name (if applicable), and HPID or OEID; (2) a draft denial letter patterned after the applicable model letter in section 15.7.9.7; and (3) the contractor's rationale for proposing to deny the application. The PEOG BFL will review the matter and advise the contractor as to how to proceed.

Grounds for denial include, but are not limited to, the following:

(1) The entity does not comply with all applicable registration requirements.

(2) The entity does not satisfy all of the requirements described in 42 CFR § 424.66. (The contractor can contact its PEOG BFL for assistance on this issue.)

(3) The entity or any of its 5 percent or greater direct or indirect owners, managing employees, corporate officers, or corporate directors - or any entity or individual with a general partnership interest or a 10 percent or greater limited partnership interest in the entity - is excluded or debarred per the Medicare Exclusion Database (MED) *and* the *SAM.*

If the contractor believes that any other ground for denial exists, it shall include this in its e-mail to its PEOG BFL.

If PEOG authorizes the denial, the contractor shall (1) switch the PECOS record to "Denied," and (2) send the denial letter via certified mail to the entity no later than 3 business days after the contractor received authorization of the denial from PEOG.

As indicated in the model denial letter in section 15.7.9.7, an entity may appeal the denial of its IPP registration application. Although IPP entities are neither providers nor suppliers, the procedures in sections 15.25.2 through 15.25.2.3 of this chapter shall apply to IPP appeals.

C. Rejection

The Form CMS-855 shall be rejected if (1) the entity fails to furnish all required information on the form within 30 calendar days of the contractor's request to do so, or (2) the entity fails to timely submit new or corrected information in the scenarios described in section 15.8.2 of this chapter. (This includes situations in which information was submitted, but could not be verified.) The basis for rejection shall be 42 CFR § 424.525(a). The rejection letter shall follow the format of the applicable letter in section 15.7.9.7 and shall be sent via regular mail no later than 5 business days after the contractor determines that the application should be rejected.

Prior PEOG approval of the rejection is unnecessary. However, as stated earlier, if the entity indicates that it is unable to furnish certain data elements because said elements do not apply to it, the contractor shall contact its PEOG BFL for guidance.

15.7.9.5 – Revocation of Registration

(Rev. 636, Issued: 02-04-16, Effective: 03-04-16- Implementation: 03-04-16)

If the contractor determines that the entity no longer meets all necessary requirements, it shall send an e-mail to its *CMS* Provider Enrollment *& Oversight* Group Business Function Lead (PEOG BFL) that contains: (1) the entity's legal business name, "doing business as" name (if applicable), and HPID or OEID; (2) a draft revocation letter patterned after the applicable model letter in section 15.7.9.7 below; and (3) the contractor's rationale for proposing to revoke the entity's registration. The PEOG BFL will review the matter and advise the contractor as to how to proceed.

Grounds for revocation include, but are not limited to, the following:

(1) The entity no longer complies with all applicable registration requirements.

(2) The entity no longer appears to be in compliance with the provisions of 42 CFR §424.66. (The contractor can contact its PEOG BFL for assistance regarding grounds (1) and (2).)

(3) The entity has not complied with the terms of its signed Form CMS-855 certification statement (e.g., has not timely submitted an update to its registration information).

(4) The entity or any of its 5 percent or greater direct or indirect owners, managing employees, corporate officers, or corporate directors - or any entity or individual with a general partnership interest or a 10 percent or greater limited partnership interest in the entity - is excluded or debarred per the Medicare Exclusion Database (MED) and/or the *SAM*..

If the contractor believes that any other ground for revocation exists, it shall include this in its e-mail to its PEOG BFL.

If PEOG authorizes the revocation, the contractor shall (1) switch the PECOS record to "Revoked," and (2) send the revocation letter via certified mail to the entity no later than 5 business days after the contractor received authorization of the revocation from PEOG.

As indicated in the model revocation letter in section 15.7.9.7 below, an entity may appeal the revocation of its IPP registration. Although IPP entities are neither providers nor suppliers, the procedures in sections 15.25.2 through 15.25.2.3 of this chapter shall apply to IPP appeals.

15.7.9.7 – Registration Letters

(Rev. 636, Issued: 02-04-16, Effective: 03-04-16- Implementation: 03-04-16)

The contractor shall use the following letters when approving, denying, or rejecting an application, or when revoking an entity's registration.

A. Approval

CMS alpha representation
Contractor

[Month Day & Year]

[Entity Name]
[Address]
[City, State & zip code]

Dear [Entity name]:

We are pleased to inform you that your Medicare Form CMS-855C registration application as an Indirect Payment Procedure (IPP) entity has been approved. Listed below is the information reflected in your Medicare Form CMS-855C record, including your Provider Transaction Access Number (PTAN).

For more information on how to bill Medicare, please contact our XXXXXXXX department at [insert phone number].

Your PTAN is also activated for use 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 for inquiries concerning claims status, beneficiary eligibility and to check status or other related transactions. Please keep your PTAN secure.

Medicare Information

Entity name:	[Insert name]
Business address:	[Insert address]
PTAN:	[Insert PTAN]
Status:	IPP Entity

Please verify the accuracy of this information. If you disagree with this initial determination or have any questions regarding the information above, call [insert applicable Medicare contractor name] at [insert Medicare contractor phone number] between the hours of [insert hours of operation].

Consistent with 42 CFR §424.516, you must submit updates and changes to your Form CMS-855C information in accordance with specified timeframes. Reportable changes include, but are not limited to, changes in: (1) legal business name (LBN)/tax identification number (TIN), (2) business address, and (3) payment information (such as changes in electronic funds transfer information). To download the CMS-855 applications, go to http://www.cms.hhs.gov/MedicareProviderSupEnroll.

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

Sincerely,

[Your Name]
[Title]

B. Denial

CMS alpha representation
Contractor

[Month Day & Year]

[Entity name]
[Address]
[City, State & zip code]

RE: [insert decision]

Dear [Entity name]:

We have received and reviewed your Form CMS-855C registration application as an Indirect Payment Procedure (IPP) entity. Your application is denied. We have determined that you do not meet the conditions necessary to bill Medicare as an IPP entity.

FACTS: [Insert ALL the reason(s) for denial and cite the applicable regulatory authority]

(Repeat for multiple, if necessary)

If you believe that you are able to correct the deficiencies and establish your eligibility to bill Medicare as an IPP entity, 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 the necessary registration requirements and must be signed and dated by an authorized official of the entity. CAP requests should be sent to:

Centers for Medicare & Medicaid Services
Provider Enrollment *& Oversight* Group
Mail Stop 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 who was not involved in the initial determination. You must request the reconsideration in writing to the office listed below within 60 calendar days of the postmark date of this letter. The request for reconsideration must state the issues, or the findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the reconsideration request that you believe may have a bearing on the decision. The reconsideration request must be signed and dated by an authorized official of the entity. Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review. [The following statement should only be used if the denial involves exclusions or sanction: 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 request for reconsideration should be sent to:

Centers for Medicare & Medicaid Services

Provider Enrollment *& Oversight* Group
Mail Stop AR-18-50
7500 Security Boulevard
Baltimore, MD 21244-1850

If you have any questions regarding this letter, please call [phone number] between the hours of [insert office hours].

Sincerely,

[Your Name]
[Title]

C. Rejection

CMS alpha representation
Contractor

[Month Day & Year]

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

Dear [Entity name]:

We received your Medicare Form CMS-855C registration application on [insert date]. We are rejecting your application and returning it to you for the following reason(s):

FACTS: [Insert ALL rejection reason(s) and cite the applicable regulatory authority]

(Repeat for multiple, if necessary)

Consistent with 42 CFR §424.525, prospective Indirect Payment Procedure (IPP) entities are required to submit a complete registration application and all necessary supporting documentation within 30 calendar days from the date of the contractor's request for missing/incomplete/clarifying information. If you would like to resubmit your registration application, please make sure to address the issues stated above and to sign and date the new certification statement page on your resubmitted application.

To submit a new registration application, you may download and complete the application from the Centers for Medicare & Medicaid Services (CMS) Web site at http://www.cms.hhs.gov/MedicareProviderSupEnroll.

You should return the complete application to the address listed below:

[Insert contact address]

If you have any questions regarding this letter, please call [phone number] between the hours of [insert office hours].

Sincerely,

[Your Name]
[Title]

D. Revocation

CMS alpha representation
Contractor

[Month Day & Year]

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

[RE:]

Dear [Entity name]:

This is to inform you that your Medicare registration as an Indirect Payment Procedure (IPP) entity is being revoked effective [insert effective date of revocation].

FACTS: [Insert ALL reason(s) for revocation and cite the applicable regulatory authority]

If you believe that you are able to correct the deficiencies and re-establish your eligibility to be registered as an IPP entity, 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 all registration requirements. The CAP request must be signed and dated by an authorized official of the entity. . CAP requests should be sent to:

Centers for Medicare & Medicaid Services
Provider Enrollment *& Oversight* Group
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 who was not involved in the initial determination. You must request the reconsideration in writing to the office listed below within 60 calendar days of the postmark date of this letter. The request for reconsideration must state the issues, or the findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the reconsideration request that you believe may have a bearing on the decision. The reconsideration request must be signed and dated by an authorized official of the entity. . Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review. [The following statement should only be used if the revocation involves exclusions or sanction: 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 request for reconsideration should be sent to:

Centers for Medicare & Medicaid Services
Provider Enrollment *& Oversight* Group
7500 Security Blvd.
Mailstop: AR-18-50
Baltimore, MD 21244-1850

Consistent with 42 CFR §424.535(c), [insert contractor name] is establishing a re-registration bar for a period of [insert amount of time]. This bar only applies to your registration in the Medicare program. In order to re-register, you must meet all registration requirements.

If you have any questions regarding this determination, please contact [insert contact name] at [insert phone number] between the hours of [insert office hours].

Sincerely,

[Your Name]
[Title]

15.8.1 – Returns

(Rev. 636, Issued: 02-04-16, Effective: 03-04-16- Implementation: 03-04-16)

A. Reasons for Return

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

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

- The contractor received the application more than 60 days prior to the effective date listed on the application. (This does not apply to: (1) providers and suppliers submitting a Form CMS-855A application, (2) ambulatory surgical centers (ASCs), or (3) portable x-ray suppliers (PXRSs).

- The contractor received an initial application from (1) a provider or supplier submitting a Form CMS-855A application, (2) an ASC, or (3) a PXRS, more than 180 days prior to the effective date listed on the application.

- An old owner or new owner in a CHOW submitted its application more than 90 days prior to the anticipated date of the sale. (This only applies to Form CMS-855A applications.)

- The contractor can confirm that the provider or supplier submitted an initial enrollment application prior to the expiration of the time period in which it is entitled to appeal the denial of its previously submitted application.

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

- The application is to be returned per the instructions in section 15.7.7.1.4 of this chapter.

- The application is not needed for the transaction in question. Two common examples include:

    - An enrolled physician wants to change his/her reassignment of benefits from one group to another group and submits a Form CMS-855I and a Form CMS-855R. As only the Form CMS-855R is needed, the Form CMS-855I shall be returned.

    - A physician who is already enrolled in Medicare submits a Form CMS-855O application, thinking that he must do so in order to refer services for Medicare beneficiaries. The Form CMS-855O can be returned, as the physician is already enrolled via the Form CMS-855I.

The contractor need not request additional information in any of these scenarios. For instance, if the application is not necessary for the particular transaction, the contractor can return the application immediately. If an application fee has already been submitted, the contractor shall follow existing instructions regarding the return of the fee.

The difference between a “rejected” application and a “returned” application is that the former is typically based on the provider’s failure to respond to the contractor’s request for missing or clarifying information. A “returned” application is effectively considered a non-application.

B. Procedures for Returning the Application

If the contractor returns the application:

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

- It shall not enter the application into PECOS. No logging & tracking (L & T) record shall be created.

- Any application resubmission must contain a brand new certification statement page containing a signature and date. The provider cannot simply add its signature to the original certification statement it submitted. (This does not apply to e-signature situations.)

It shall return all paper documents submitted with the paper or Internet-based PECOS application (e.g., Form CMS-588, Form CMS-460). The contractor shall, however, make and keep a photocopy or scanned version of the paper application (if applicable) and any paper documents (regardless of whether the application was submitted via paper or electronically) prior to returning them.

C. Other Impacts of a Return

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

a. Expiration of Timeframe for Reporting Changes - If the contractor returns a change of information or CHOW submission per this section 15.8.1 and the applicable 90-day or 30-day period for reporting the change has expired, the contractor shall send an e-mail to its *CMS* Provider Enrollment *& Oversight* Group Business Function Lead (PEOG BFL) notifying him or her of the return. PEOG will determine whether the provider's Medicare billing privileges should be deactivated under 42 CFR § 424.540(a)(2) or revoked under 42 CFR § 424.535(a)(1) or (a)(9) and will notify the contractor of its decision.

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

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

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

3. Revalidations – If the contractor returns a revalidation application per this section 15.8.1, the contractor shall – unless an existing CMS instruction or directive dictates otherwise - deactivate 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 deactivate the provider's billing privileges after the applicable time period expires unless the provider has resubmitted the revalidation application. If the provider has resubmitted the application and the contractor (1) returns it again, (2) rejects it per section 15.8.2 of this chapter, or (3) denies it, the contractor shall - unless an existing CMS instruction or directive dictates otherwise – deactivate the provider's billing privileges, assuming the applicable time period has expired.

15.8.4 – Denials

(Rev. 636, Issued: 02-04-16, Effective: 03-04-16- Implementation: 03-04-16)

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 *CMS' Provider Enrollment & Oversight Group (PEOG)* of the denial or the denial letter.

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

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 *PEOG* 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 *PEOG* 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 *PEOG* via the MACRevocationRequests@cms.hhs.gov mailbox prior to sending the denial letter. *PEOG* will notify the contractor of its determinations and instruct the contractor as to how to proceed.

2. Prior *PEOG* Approval Unnecessary

When a decision to deny is made, the contractor shall send a letter to the provider identifying the reason(s) for denial and furnishing appeal rights. The letter shall follow the format of those shown in section 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 *PEOG* of the denial. *PEOG* will determine whether the provider's Medicare billing privileges should be deactivated under 42 CFR § 424.540(a)(2) or revoked under 42 CFR § 424.535(a)(1) or (a)(9) and will notify the contractor of its decision.

b. Timeframe Not Yet Expired - If the contractor denies a change of information or CHOW submission and the applicable 90-day or 30-day period for reporting the change has not yet expired, the contractor shall send the e-mail referred to in (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. *PEOG* will determine whether the provider's Medicare billing privileges should be deactivated under 42 CFR § 424.540(a)(2) or revoked under 42 CFR § 424.535(a)(1) or (a)(9) and will notify the contractor of its decision.

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 chapter.

15.9.1 - Non-Certified Suppliers and Individual Practitioners

(Rev. 636, Issued: 02-04-16, Effective: 03-04-16- Implementation: 03-04-16)

(This section does not apply to ambulatory surgical centers, portable x-ray suppliers, or providers and suppliers that complete the Form CMS-855A.)

If the contractor approves a supplier's enrollment, it shall notify the applicant via letter of the approval. The letter shall:

- Follow the content and format of the model letter in section 15.24.7 of this chapter;

- Include the National Provider Identifier (NPI) with which the supplier will bill Medicare and the Provider Transaction Access Number (PTAN) that has been assigned to the supplier as an identifier for inquiries.

- Provide instructions on how suppliers should use the assigned PTAN when they use the contractor interactive voice response (IVR) system for inquiries concerning claims status, beneficiary eligibility, check status or other supplier-related IVR transactions.

- Include language reminding suppliers to update their NPPES record whenever their information changes.

Absent a CMS instruction or directive to the contrary, *the contractor shall send the approval letter within 5 business days of approving the enrollment application in PECOS*. *For all applications other than the Form CMS-855S,* the letter *shall* be sent to the supplier's contact person if one is listed; *otherwise, the contractor may send the letter to the supplier at the supplier's correspondence address or special payment address.*

For claims submitted by physicians and non-physicians prior to the date of enrollment, the contractor shall follow the instructions in Pub. 100-04, chapter 1, section 70, with respect to the claim filing limit. Payments cannot be made for services furnished prior to the date the applicant is appropriately licensed.

15.13 – Existing or Delinquent Overpayments

(Rev. 636, Issued: 02-04-16, Effective: 03-04-16- Implementation: 03-04-16)

Consistent with 42 CFR §424.530(a)(6), an enrollment application may be denied if: (1) the current owner (as that term is defined in 42 CFR §424.502) of the applying provider or supplier, or (2) the applying physician or non-physician practitioner, has an existing overpayment that is equal to or exceeds a threshold of $1,500 and it has not been repaid in full at the time the application was filed. To this end, the contractor shall:

- When processing a Form CMS-855A, CMS-855B, or 855S initial or change of ownership application, determine – using a system generated daily listing - whether any of the owners listed in section 5 or 6 of the application has an existing or delinquent Medicare overpayment.

- When processing a Form CMS-855I initial application, determine – using a system generated daily listing - whether the physician or non-physician practitioner has an existing or delinquent Medicare overpayment. (For purposes of this requirement, the term "non-physician practitioner" includes physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse-midwives, clinical social workers, clinical psychologists, and registered dietitians or nutrition professionals.)

If an owner, physician, or non-physician practitioner has such an overpayment, the contractor shall deny the application, using 42 CFR §424.530(a)(6) as the basis. However, prior approval from *CMS'* Provider Enrollment *& Oversight* Group (PEOG) is required before proceeding with the denial. The contractor shall under no circumstances deny an application under §424.530(a)(6) without receiving PEOG approval to do so.

Consider the following examples:

Example #1: Hospital X has a $200,000 overpayment. It terminates its Medicare enrollment. Three months later, it reopens as Hospital Y and submits a new *Form* CMS-855A application for enrollment as such. A denial is not warranted because §424.530 (a)(6) only applies to physicians, practitioners, and owners.

Example #2: Dr. John Smith's practice ("Smith Medicine") is set up as a sole proprietorship. He incurs a $50,000 overpayment. He terminates his Medicare enrollment. Six months later, he tries to enroll as a sole proprietorship; his practice is named "JS Medicine." A denial is warranted because §424.530 (a)(6) applies to physicians and the $50,000 overpayment was attached to him as the sole proprietor.

Example #3 - Same scenario as example #2, but assume that his new practice is an LLC of which he is only a 30 percent owner. A denial is not warranted because the provision applies to owners and, again, the $50,000 overpayment was attached to him.

Example #4 - Jane Smith is a nurse practitioner in a solo practice. Her practice ("Smith Medicine") is set up as a closely-held corporation, of which she is the 100 percent owner. Smith Medicine is assessed a $20,000 overpayment. She terminates her Medicare enrollment. Nine months later, she submits a *Form* CMS-855I application to enroll Smith Medicine as a new supplier. The business will be established as a sole proprietorship. A denial is not warranted because the $20,000 overpayment was attached to Smith Medicine, not to Jane Smith.

Excluded from denial under §424.535(a)(6) are individuals or entities (1) on a Medicare-approved plan of repayment or (2) whose overpayments are currently being offset or being appealed.

NOTE: The contractors shall also observe the following:

- In determining whether an overpayment exists, the contractor need only review its own records; it need not contact other contractors to determine whether the person or entity has an overpayment in

those contractor jurisdictions.

- The instructions in this section 15.8.4 apply only to (1) initial enrollments, and (2) new owners in a change of ownership.

The term "owner" under section §424.502 means any individual or entity that has any partnership interest in, or that has 5 percent or more direct or indirect ownership of the provider or supplier as defined in sections 1124 and 1124A(A) of the Act)

- If the person or entity had an overpayment at the time the application was filed but repaid it in full by the time the contractor performed the review described in this section 15.8.4, the contractor shall not deny the application based on 42 CFR §424.530(a)(6).

15.14.2 – Contractor Communications

(Rev. 636, Issued: 02-04-16, Effective: 03-04-16- Implementation: 03-04-16)

Medicare contractors create Associate and Enrollment Records in the Provider Enrollment, Chain and Ownership System (PECOS). Ownership of an Associate or Enrollment Record belongs to the contractor within whose jurisdiction the provider/supplier is located. PECOS only permits the contractor that created the Associate or Enrollment Record (the "owning contractor") to make updates, changes, or corrections to those records. (That is, the owning contractor is the only contractor that can make changes to the associate record.)

Occasionally, updates, changes, or corrections do not come to the owning contractor's attention, but instead go to a different contractor. In those situations, the contractor that has been notified of the update/change/correction (the "requesting" contractor) must convey the changed information to the owning contractor so that the latter can update the record in PECOS.

The requesting contractor may notify the owning contractor via fax of the need to update/change/correct information in a provider's PECOS record. The notification must contain:

1. The provider's legal business name, Provider Transaction Access Number, and National Provider Identifier; and

2. The updated/changed/corrected data (by including a copy of the appropriate section of the Form CMS-855).

Within 7 calendar days of receiving the requesting contractor's request for a change to a PECOS record, the owning contractor shall make the change and notify the requesting contractor thereof via fax, e-mail, or telephone.

If the owning contractor is reluctant to make the change, it shall contact its *CMS* Provider Enrollment *& Oversight* Group (PEOG) liaison for guidance. Note that the owning contractor may ask the requesting contractor for any additional information about the provider it deems necessary (e.g., IRS documentation, licenses).

The owning contractor need not ask the provider for a Form CMS-855 change of information in associate profile situations. It can simply use the Form CMS-855 copy that the requesting contractor sent/faxed to the owning contractor. For instance, suppose Provider X is enrolled in two different contractor jurisdictions – A and B. The provider enrolled with "A" first; its legal business name was listed as "John Brian Smith Hospital." It later enrolls with "B" as "John Bryan Smith Hospital." "B" has verified that "John Bryan Smith Hospital" is the correct name and sends a request to "A" to fix the name. "A" is not required to ask the provider to submit a Form CMS-855A change of information. It can use the CMS-855A copy that it received from "B."

15.19.1 – Application Fees

(Rev. 636, Issued: 02-04-16, Effective: 03-04-16- Implementation: 03-04-16)

A. Background

Pursuant to 42 CFR § 424.514 - and with the exception of physicians, non-physician practitioners, physician group practices and non-physician group practices – institutional providers that are (1) initially enrolling in Medicare, (2) adding a practice location, or (3) revalidating their enrollment information per 42 CFR § 424.515 (regardless of whether the revalidation application was requested by CMS or voluntarily submitted by the provider or supplier), must submit with their application:

- An application fee in an amount prescribed by CMS, and/or
- A request for a hardship exception to the application fee.

This requirement applies to applications that the contractor receives on or after March 25, 2011.

For purposes of this requirement, the term "institutional provider," as defined in 42 CFR §424.502, means any provider or supplier that submits a paper Medicare enrollment application using the Form CMS-855A, Form CMS-855B (not including physician and non-physician practitioner organizations), Form CMS-855S or associated Internet-based Provider Enrollment, Chain and Ownership System (PECOS) enrollment application. A physician, non-physician practitioner, physician group, or non-physician practitioner group that is enrolling as a supplier of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) via the Form CMS-855S application must submit the required application fee with its Form CMS-855S form.

B. Fee

1. Amount

The application fee must be in the amount prescribed by CMS for the calendar year (1) in which the application is submitted (for Internet-based PECOS applications) or (2) of the postmark date (for paper applications). The fee for March 25, 2011 through December 31, 2011 was $505.00. The fee for January 1, 201*6* through December 31, 201*6* is $55*4*.00. Fee amounts for future years will be adjusted by the percentage change in the consumer price index (for all urban consumers) for the 12-month period ending on June 30 of the prior year. CMS will give the contractor and the public advance notice of any change in the fee amount for the coming calendar year.

2. Non-Refundable

Per 42 CFR § 424.514(d)(2)(v), the application fee is non-refundable, except if it was submitted with one of the following:

a. A hardship exception request that is subsequently approved;

b. An application that was rejected prior to the contractor's initiation of the screening process, or

c. An application that is subsequently denied as a result of the imposition of a temporary moratorium under 42 CFR § 424.570.

(For purposes of (B)(2)(b) above, the term "rejected" includes applications that are returned pursuant to section 15.8.1 of this *c*hapter.)

In addition, the fee should be refunded if:

- It was not required for the transaction in question (e.g., the provider submitted a fee with its application to report a change in phone number).

- It was not part of an application submission.

3. Format

The provider or supplier must submit the application fee electronically through https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do, either via credit card, debit card, or check.

Also, with respect to the application fee requirement:

- The fee is based on the Form CMS-855 application submission, not on how enrollment records are created in PECOS. For instance, suppose a hospital submits an initial Form CMS-855A. In section 2A2 of the application, the hospital indicates that it has a psychiatric unit and a rehabilitation unit. Separate PECOS enrollment records must be created for each unit. However, only one application fee is required because only one Form CMS-855A application was submitted.

- A physician/non-physician practitioner clinic or group practice enrolling via the Form CMS-855B is exempt from the fee even if it is: (1) tribally-owned/operated or (2) hospital-owned. However, if a hospital is adding a physician/non-physician practitioner clinic or group practice to its Form CMS-855A enrollment, a fee is required because the hospital is adding a practice location.

C. Hardship Exception

1. Background

A provider or supplier requesting a hardship exception from the application fee must include with its enrollment application a letter (and any supporting documentation) that describes the hardship and why the hardship justifies an exception. If a paper Form CMS-855 application is submitted, the hardship exception letter must accompany the application; if the application is submitted via Internet-based PECOS, the hardship exception letter must accompany the certification statement. Hardship exception letters shall not be considered if they were submitted separately from the application or certification statement, as applicable. If the contractor receives a hardship exception request separately from the application or certification statement, it shall: (1) return it to the provider, and (2) notify the provider via letter, e-mail or telephone that it will not be considered.

2. Criteria for Determination

The application fee generally should not represent a significant burden for an adequately capitalized provider or supplier. Hardship exceptions should not be granted when the provider simply asserts that the imposition of the application fee represents a financial hardship. The provider must instead make a strong argument to support its request, including providing comprehensive documentation (which may include, without limitation, historical cost reports, recent financial reports such as balance sheets and income statements, cash flow statements, tax returns, etc.).

Other factors that may suggest that a hardship exception is appropriate include the following:

(a) Considerable bad debt expenses,

(b) Significant amount of charity care/financial assistance furnished to patients,

(c) Presence of substantive partnerships (whereby clinical, financial integration are present) with those who furnish medical care to a disproportionately low-income population;

(d) Whether an institutional provider receives considerable amounts of funding through disproportionate share hospital payments, or

(e) Whether the provider is enrolling in a geographic area that is a Presidentially-declared disaster under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121-5206 (Stafford Act).

Upon receipt of a hardship exception request with the application or certification statement, the contractor shall send the request and all documentation accompanying the request via regular mail, fax, or e-mail to *its* CMS Provider Enrollment *& Oversight Group* Business Function Lead (PEOG BFL). CMS has 60 calendar days from the date of the contractor's receipt of the hardship exception request to determine whether it should be approved; during this period, the contractor shall not commence processing the provider's application. CMS will communicate its decision to the provider and the contractor via letter, after which the contractor shall carry out the applicable instructions in section 19.1(D) below.

If the provider fails to submit appropriate documentation to support its request, the contractor is not required to contact the provider to request it. The contractor can simply forward the request "as is" to its PEOG BFL. Ultimately, it is the provider's responsibility to furnish the necessary supporting evidence at the time it submits its hardship exception request.

D. Receipt

Upon receipt of a paper application (or, if the application is submitted via Internet-based PECOS, upon receipt of a certification statement) from a provider or supplier that is otherwise required to submit an application fee, the contractor shall first determine whether the application is an initial enrollment, a revalidation, or involves the addition of a practice location. If the application does not fall within any of these categories, the contractor shall process the application as normal. If it does fall within one of these categories, the contractor shall undertake the following:

a. Determine whether the provider has: (1) paid the application fee via Pay.gov, and/or (2) included a hardship exception request with the application or certification statement.

b. If the provider:

i. Has neither paid the fee nor submitted the hardship exception request, the contractor shall send a letter to the provider notifying it that it has 30 days from the date of the letter to pay the application fee via Pay.gov, and that failure to do so will result in the rejection of the provider's application (for initial enrollments and new practice locations) or revocation of the provider's Medicare billing privileges (for revalidations). The letter shall also state that because a hardship exception request was not submitted with the original application, CMS will not consider granting a hardship exception in lieu of the fee.

During this 30-day period, the contractor shall determine whether the fee has been paid via Pay.gov. If the fee is paid within the 30-day period, the contractor may begin processing the application as normal. If the fee is not paid within the 30-day period, the contractor shall reject the application (initial enrollments and new locations) under 42 CFR §424.525(a)(3) or revoke the provider's Medicare billing privileges under 42 CFR §424.535(a)(6) (revalidations).

If, at any time during this 30-day period, the provider submits a Pay.gov receipt as proof of payment, the contractor shall begin processing the application as normal.

ii. Has paid the fee but has not submitted a hardship exception request, the contractor shall begin processing the application as normal.

iii. Has submitted a hardship exception request but has not paid a fee, the contractor shall send the request and all documentation accompanying the request via regular mail, fax, or e-mail to its PEOG BFL. If CMS:

a. Denies the hardship exception request, it will notify the provider in the decision letter (on which the contractor will be copied) that the application fee must be paid within 30 calendar days from the date of the letter. During this 30-day period, the contractor shall determine whether the fee has been submitted via Pay.gov. If the fee is not paid within 30 calendar days, the contractor shall deny the application (initial enrollments and new locations) pursuant to 42 CFR § 424.530(a)(9) or revoke the provider's Medicare billing privileges under 42 CFR § 424.535(a)(6) (revalidations).

If, at any time during this 30-day period, the provider submits a Pay.gov receipt as proof of payment, the contractor shall begin processing the application as normal.

b. Approves the hardship exception request, it will notify the provider of such in the decision letter (on which the contractor will be copied). The contractor shall begin processing the application as normal.

iv. Has submitted a hardship exception request and has paid a fee, the contractor shall send the request and all documentation accompanying the request via regular mail, fax, or e-mail to its PEOG BFL. As the fee has been paid, the contractor shall begin processing the application as normal.

In all cases, the contractor shall not begin processing the provider's application until: (1) the fee has been paid, or (2) the hardship exception request has been approved.

E. Year-to-Year Transition

There may be isolated instances where, at the end of a calendar year, an institutional provider pays the fee amount for that year (Year 1), yet the submission date (for Internet-based PECOS applications) or the application postmark date (for paper applications) falls in the beginning of the following year (Year 2). Assuming that Year 2's fee is higher than Year 1's, the provider will be required to pay the Year 2 fee. The contractor shall not begin processing the application until the entire fee amount has been paid. Accordingly, the contractor shall (1) send an e-mail to its *PEOG BFL* requesting a full refund of the fee and including any pertinent documentation in support of the request, and (2) send a letter to the provider notifying it that it has 30 days from the date of the letter to pay the correct fee amount (i.e., the Year 2 amount) via Pay.gov, and that failure to do so will result in the rejection of the provider's application (for initial enrollments and new practice locations) or revocation of the provider's Medicare billing privileges (for revalidations). The letter shall also state that because a hardship exception request was not submitted with the original application, CMS will not consider granting a hardship exception in lieu of the fee.

During this 30-day period, the contractor shall determine whether the correct fee has been paid via Pay.gov. If it has been, the contractor may begin processing the application as normal. If it is not paid within the 30-day period, the contractor shall reject the application (initial enrollments and new locations) under 42 CFR § 424.525(a)(3) or revoke the provider's Medicare billing privileges under 42 CFR § 424.535(a)(6) (revalidations).

If, at any time during this 30-day period, the provider submits a Pay.gov receipt as proof that the correct fee amount (i.e., the Year 2 amount) has been paid, the contractor shall begin processing the application as normal.

F. Appeals of Hardship Determinations

A provider may appeal CMS' denial of its hardship exception request via the procedures outlined below:

1. If the provider is dissatisfied with CMS' decision to deny a hardship exception request, it may file a written reconsideration request with CMS within 60 calendar days from receipt of the notice of initial determination (e.g., CMS' denial letter). The request must be signed by the individual provider or supplier, a legal representative, or any authorized official within the entity. Failure to file a reconsideration request within this timeframe is deemed a waiver of all rights to further administrative review.

The reconsideration request should be mailed to:

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

Notwithstanding the filing of a reconsideration request, the contractor shall still carry out the post-hardship exception request instructions in subsections (D)(b)(iii)(a) and (iv) above, as applicable. A reconsideration request, in other words, does not stay the execution of the instructions in section 19.1(D) above.

CMS has 60 calendar days from the date of the reconsideration request to render a decision. The reconsideration shall be:

(a) Conducted by a CMS staff person who was independent from the initial decision to deny the hardship exception request.

(b) Based on CMS' review of the original letter and documentation submitted by the provider.

Upon receipt of the reconsideration, CMS will send a letter to the provider or supplier to acknowledge receipt of its request. In its acknowledgment letter, CMS will advise the requesting party that the reconsideration will be conducted and a determination issued within 60 days from the date of the request.

If CMS denies the reconsideration, it will notify the provider of this via letter, with a copy to the contractor. If CMS approves the reconsideration request, it will notify the provider of this via letter, with a copy to the contractor, after which the contractor shall process the application as normal, or, to the extent applicable:

i. If the application has already been rejected, request that the provider resubmit the application without the fee, or

ii. If Medicare billing privileges have already been revoked, reinstate said billing privileges in accordance with existing instructions and request that the provider resubmit the application without the fee.

Corrective Action Plans (CAPs) may not be submitted in lieu of or in addition to a request for reconsideration of a hardship exception request denial.

2. If the provider is dissatisfied with the reconsideration determination regarding the application fee, it may request a hearing before an Administrative Law Judge (ALJ). Such an appeal must be filed, in writing, within 60 days from receipt of the reconsideration decision. ALJ requests should be sent to:

Department of Health and Human Services

Departmental Appeals Board (DAB)
Civil Remedies Division, Mail Stop 6132
330 Independence Avenue, S.W.
Cohen Bldg, Room G-644
Washington, D.C. 20201
ATTN: CMS Enrollment Appeal

Failure to timely request an ALJ hearing is deemed a waiver of all rights to further administrative review.

If the ALJ reverses PEOG's reconsideration decision and approves the hardship exception request, and the application has already been rejected, the contractor – once PEOG informs it of the ALJ's decision - shall notify the provider via letter, e-mail or telephone that it may resubmit the application without the fee. If the provider's Medicare billing privileges have already been revoked, the contractor shall reinstate said billing privileges in accordance with existing instructions and request that the provider resubmit the application without the fee.

3. If the provider is dissatisfied with the ALJ's decision, it may request Board review by the Departmental Appeals Board (DAB). Such request must be filed within 60 days after the date of receipt of the ALJ's decision. Failure to timely request a review by the DAB is deemed a waiver of all rights to further administrative review.

If the DAB reverses the ALJ's decision and approves the hardship exception request, and the application has already been rejected, the contractor - once PEOG informs it of the DAB's decision - shall notify the provider via letter, e-mail or telephone that it may resubmit the application without the fee. If the provider's Medicare billing privileges have already been revoked, the contractor shall reinstate said billing privileges in accordance with existing instructions and request that the provider resubmit the application without the fee.

To the extent permitted by law, a provider or supplier dissatisfied with a DAB decision may seek judicial review by timely filing a civil action in a United States District Court. Such request shall be filed within 60 days from receipt of the notice of the DAB's decision.

G. Miscellaneous

The contractor shall abide by the following:

1. Paper Checks Submitted Outside of Pay.gov – As stated earlier, all payments must be made via Pay.gov. Should the provider submit an application with a paper check or any other hard copy form of payment (e.g., money order), the contractor shall not deposit the instrument. It shall instead treat the situation as a non-submission of the fee and follow the instructions in (D)(b)(i) or (iii) above (depending on whether a hardship exception request was submitted). When sending the applicable letter requesting payment within 30 days, the contractor shall explain that all payments must be made via.Pay.gov, stamp the submitted paper check "VOID," and include the voided paper check with the letter.

2. Practice Locations – DMEPOS suppliers, federally qualified health centers (FQHCs), and independent diagnostic testing facilities (IDTFs) must individually enroll each site. Consequently, the enrollment of each site requires a separate fee. For **all other providers and suppliers** (except physicians, non-physician practitioners, and physician and non-physician practitioner groups, none of which are required to submit the fee), a fee must accompany any application that adds a practice location. (This includes the addition of a hospital unit – such as a psychiatric unit – in section 4 of the Form CMS-855A.) If multiple locations are being added on a single application, however, only one fee is required. The fee for providers and suppliers other than DMEPOS suppliers, FQHCs, and IDTFs is based on the application submission, not the number of locations being added on a single application.

3. Other Application Submissions – A provider or supplier need not pay an application fee if the application is:

   - Reporting a change of ownership via the Form CMS-855B or Form CMS-855S. (For providers and suppliers reporting a change of ownership via the Form CMS-855A, the ownership change does not necessitate an application fee if the change does not require the provider or supplier to enroll as a new provider or supplier.)

   - Reporting a change in tax identification number (whether Part A, Part B, or DMEPOS).

   - Requesting a reactivation of the provider's Medicare billing privileges unless the provider had been deactivated for failing to respond to a revalidation request, in which case the resubmitted application constitutes a revalidation (not a reactivation) application, hence requiring a fee.

   - Changing the physical location of an existing practice location (as opposed to reporting an additional/new practice location).

   The application fee requirement is separate and distinct from the site visit requirement and risk categories discussed below. Physicians, non-physician practitioners, physician groups and non-physician practitioner groups are exempt from the application fee even if they fall within the "high" level of categorical screening per section 15.19.2.5 of this chapter. Similarly, physical therapists enrolling as individuals or group practices need not pay an application fee even though they fall within the "moderate" level of categorical screening and are subject to a site visit.

4. Non-Payment of the Fee - If the application is rejected or denied due to non-payment of the fee, the contractor shall:

   - Enter the application into PECOS, with the receipt date being the date on which the contractor received the application in its mailroom.

   - Indicate in PECOS that a developmental request was made.

   - Switch the enrollment record to a "denied" or "rejected" status (as applicable) per section 15.19.1(D).

   - Notify the applicant of the rejection or denial in accordance with section 15.19.1(D).

5. *Refund Requests – Unless otherwise approved by CMS, the provider must request a refund no later than 150 days from the date it submitted its application. In its request, the provider shall include documentation acceptable to process the refund request. For credit card refunds, the provider shall include its Pay.gov receipt or the Pay.gov tracking ID number; if the fee was paid via ACH Debit, a W-9 is required.*

15.19.2.5 – Movement of Providers and Suppliers into the High Level

(Rev. 636, Issued: 02-04-16, Effective: 03-04-16- Implementation: 03-04-16)

Under §424.518(c)(3), CMS may adjust a particular provider or supplier's screening level from "limited" or "moderate" to "high" if any of the following occur:

1. CMS imposes a payment suspension on a provider or supplier at any time within the last 10 years;

2. The provider or supplier:

    a. Has been excluded from Medicare by the Office of Inspector General; or

    b. Had its billing privileges revoked by a Medicare contractor within the previous 10 years and is attempting to establish additional Medicare billing privileges by:

        - Enrolling as a new provider or supplier; or
        - Obtaining billing privileges for a new practice location

    c. Has been terminated or is otherwise precluded from billing Medicaid

    d. Has been excluded from any Federal health care program

    e. Has been subject to any final adverse action (as defined in §424.502) within the previous 10 years.

3. CMS lifts a temporary moratorium for a particular provider or supplier type, and a provider or supplier that was prevented from enrolling based on the moratorium applies for enrollment as a Medicare provider or supplier at any time within 6 months from the date the moratorium was lifted.

CMS makes available to the contractor on a bi-monthly basis a list of current and former Medicare providers and suppliers within the contractor's jurisdiction that meet any of the criteria in subsection (1) or (2) above. Upon receipt of an initial or revalidation application from a provider or supplier that otherwise falls within the limited or moderate screening category (and after the appropriate fee has been paid, etc.), the contractor shall determine whether the provider or supplier is on the bi-monthly "high" screening list. If the provider or supplier is not on said list, the contractor shall process the application in accordance with existing instructions. If the provider or supplier is on the list, the contractor shall process the application using the procedures in the "high" screening category unless the provider is on the list solely because he/she/it was revoked for failing to timely respond to a revalidation request. If such is the case, the contractor shall contact its *CMS* Provider Enrollment *& Oversight* Group Business Function Lead for guidance as to how the situation should be handled.

With respect to subsection (3) above, if the contractor receives an initial or new location application from a provider or supplier: (a) that is of a provider or supplier type that was subject to a moratorium and (b) within 6 months after the applicable moratorium was lifted, the contractor shall process the application using the procedures in the "high" screening category.

15.22.1 – Web Sites

(Rev. 636, Issued: 02-04-16, Effective: 03-04-16- Implementation: 03-04-16)

The contractor must provide a link to CMS' provider/supplier enrollment Web site located at http://www.cms.hhs.gov/MedicareProviderSupEnroll . The link shall: (1) be available on the contractor's existing provider outreach Web site (which should be an established sub-domain of the contractor's current commercial Web site), and (2) comply with the guidelines stated in the Provider/Supplier Information and Education Web site section (Activity Code 14101) under the Provider Communications (PCOM) Budget and Performance Requirements (BPRs). Bulletins, newsletters, seminars/workshops and other information concerning provider enrollment issues shall also be made available on the existing provider outreach Web site. All contractor Web sites must comply with section 508 of the Rehabilitation Act of 1973 in accordance with, 36 CFR §1194, and must comply with CMS' Contractor Web site Standards and Guidelines posted on CMS's Web site.

The CMS Provider/Supplier Enrollment Web site, http://www.cms.hhs.gov/ MedicareProviderSupEnroll, furnishes the user with access to provider/supplier enrollment forms, specific requirements for provider/supplier types, manual instructions, frequently asked questions (FAQs), contact information, hot topics, and other pertinent provider/supplier information. The contractor shall not duplicate content already provided at the CMS provider/supplier enrollment Web site, and shall not reproduce the forms or establish the contractor's own links to forms. It shall, however, have a link on its Web site that goes directly to the forms section of the CMS provider/supplier enrollment site.

On a quarterly basis *(specifically, no later than the 15th day of January, April, July, and October),* each contractor shall review and provide updates regarding its contact information shown at URL:

http://www.cms.hhs.gov/MedicareProviderSupEnroll/downloads/contact_list.pdf

If the contractor services several States with a universal address and telephone number, the contractor shall report that information. In situations where no actions are required, a response from the contractor is still required (i.e., the contact information is accurate). In addition, only such information that pertains to provider enrollment activity for the contractor's jurisdiction is to be reported. All updates shall be sent directly via e-mail to the contractor's *CMS* Provider Enrollment *& Oversight* Group Business Function Lead.

15.23.2 – Release of Information

(Rev. 636, Issued: 02-04-16, Effective: 03-04-16- Implementation: 03-04-16)

On October 13, 2006, CMS published System of Records Notice for the Provider Enrollment, Chain and Ownership System (PECOS) in the Federal Register. Consistent with this notice, once the provider has submitted an enrollment application (as well as after it has been enrolled), the contractor shall not release – either orally or in writing - provider-specific data to any other person or entity. *(Provider-specific data includes, but are not limited to, owners/managers, adverse legal history, practice locations, group affiliations, effective dates, etc.) Examples of outside persons or entities include, but are not restricted* to, national or state medical associations or societies, clearinghouses, billing agents, provider associations, or any person within the provider's organization other than the provider's authorized official(s) (section 15 of the CMS-855), delegated official(s), (section 16), contact persons (section 13), or authorized surrogate users. The only exceptions to this policy are:

- A routine use found in the aforementioned System of Records applies.

- The provider (or, in the case of an organizational provider, an authorized or delegated official): (1) furnishes a signed written letter on the provider's letterhead stating that the release of the provider data is authorized, and (2) the contractor has no reason to question the authenticity of the person's signature. The letter can be mailed, faxed, or e-mailed to the contractor.

- The release of the data is specifically authorized in some other CMS instruction or directive.

(These provisions also apply in cases where the provider requests a copy of any Form CMS-855 paperwork the contractor has on file.)

It is recommended that the contractor notify the provider of the broad parameters of the aforementioned policy as early in the enrollment process as possible.

In addition:

- When sending e-mails, the contractor shall not transmit sensitive data, such as social security numbers or employer identification numbers.

- The contractor may not send PECOS screen printouts to the provider.

- The contractor shall not send an individual's provider transaction access numbers (PTAN) to a group or organization (including the group's authorized or delegated official). If a group/organization needs to know an individual provider's PTAN, it must contact the provider directly for this information or have the individual provider request this information in writing from the contractor. If the individual provider requests his/her PTAN number, the contractor can mail it to the provider's practice location. The contractor should never give this information over the phone.

15.24 – Model Letter Guidance

(Rev. 636, Issued: 02-04-16, Effective: 03-04-16- Implementation: 03-04-16)

A. Format Requirements

All letters sent by contractors to providers and suppliers shall consist of the following format:

- The CMS logo (2012 version) displayed per previous CMS instructions.
- The contractor's logo shall be displayed however the contractor deems appropriate. There are no restrictions on font, size, or location. The only restriction is that the contractor's logo must not conflict with the CMS logo.
- All text, with the exception of items in the header or footer, shall be written in Times New Roman 12 point font.
- All dates in letters, except otherwise specified, shall be in the following format: month/dd/yyyy (e.g., January 26, 2012).

Any exceptions to the above must be approved by the contractor's *CMS* Provider Enrollment *& Oversight* Group Business Function Lead (*PEOG* BFL).

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

- The contractor shall populate the fill-in sections with the appropriate information such as primary regulatory citation and specific denial and revocation reasons, names, addresses, etc.
- The fill-in sections shall be indented ½ inch from the normal text of the letter.
- All specific or explanatory (not primary CFR citations) reasons shall appear in **bold type.**
- There may be more than one primary reason listed.
- The static sections shall be left as-is unless there is specific guidance for removing a section (e.g., removing a CAP section for certain denial and revocation reasons; removing State survey language for certain provider/supplier types that do not require a survey). If there is no guidance for removing a static section, the contractor must obtain approval from its PEOG BFL to modify or remove such a section.

The following do not require *PEOG* BFL approval:

- Placing a reference number or numbers between the provider/supplier address and the salutation.
- Appropriate documents attached to specific letters as needed.
- Placing language in any letter regarding self-service functions such as the Provider Contact Center Interactive Voice Response (IVR) system and Electronic Data Interchange (EDI) enrollment process.

The contractor shall use the following model letter formats. Unless as stated otherwise in this chapter, any exceptions to these formats must be approved by the contractor's *PEOG* BFL.

The above format, with the exception of static and fill-in sections, shall also be used for "as needed" letters (such as letters for individual provider or supplier circumstances).

B. Sending Letters

1. *The contractor shall issue approval letters within 5 business days of approving the enrollment application in PECOS.*

2. *For all applications other than the Form CMS-855S, the contractor shall send development/approval letters/revocation letters, etc., to the contact person if one is listed; otherwise, the contractor may send the letter to the provider or supplier at the provider's/supplier's correspondence address or special payments address.*

15.24.7 – Approval Letter Guidance

(Rev. 636, Issued: 02-04-16, Effective: 03-04-16- Implementation: 03-04-16)

(The contractor may mail, e-mail, or fax the approval letter to the provider or supplier. If the fax or e-mail is not received by the provider or supplier, a letter shall be mailed.)

- Depending on the type of approval, one of the following shall be selected for insertion in the first sentence:

  [Initial Medicare enrollment application]
  [Revalidated Medicare enrollment application]
  [Change of information request]
  [Add/Terminate a Reassignment of Benefits request]

- If provider/supplier is NOT exclusively ordering or certifying, REMOVE the following sentence:

  This application is for the sole purpose of ordering or certifying items or services for Medicare beneficiaries to other providers and suppliers.

- Ordering or Certifying Providers

  The last two sentences of the 1st paragraph shall be the following:

  Listed below is your National Provider Identifier (NPI). To start billing, you must use your NPI on all Medicare claim submissions.

  REMOVE paragraph 2 and paragraph 3, which refer to PTAN usage.

  If provider/supplier IS exclusively ordering or certifying, REMOVE the following three fields:

  Practice location: [Address]
  Provider Transaction Access Number (PTAN): [PTAN]
  You are a: [participating]/[non-participating]

  The effective date field shall remain in the letter and reflect the date on which the contractor received the signed paper CMS-855O form or the Web-based certification statement/e-signature.

  Effective date: [Effective date or Termination date of Ordering or Certifying Status]

- Revalidated and Change of Ownership (CHOW) Approvals

  For revalidated and Change of Ownership (CHOW) approvals, paragraphs #2 and #3 of the letter are optional.

- If letter is NOT approving a Change of Ownership (CHOW), REMOVE the following field:

  Medicare Year End Cost Report Date: [Date]

- On the effective date field, if voluntarily terminating Medicare participation, insert "of termination" after "Effective date"

- Physicians, certain non-physician practitioners, and physician and non-physician practitioner organizations may appeal their effective date made by the contractor (JSM/TDL-11023)

- Supply additional "Medicare Enrollment Information" for each additional location and NPI/PTAN combination) only when approving an Initial or Revalidation application. If multiple locations and NPI/PTAN combinations exist, a separate document identifying this information shall be attached to the approval letter.

- Changes of information submitted to report a change to a data element other than those listed as one of the predefined elements, shall be added to the predefined list under the Medicare Enrollment Information section to acknowledge the change has been incorporated.

- The 2nd,3rd and 4th paragraphs may be edited or deleted in appropriate circumstances:

  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].

- Under "Medicare Enrollment Information, for group member enrollment, the following fields may be added:

  Group National Provider Identifier (NPI): [NPI]
  Group Provider Transaction Access Number (PTAN): [PTAN]

15.25 – Appeals Process

(Rev. 636, Issued: 02-04-16, Effective: 03-04-16- Implementation: 03-04-16)

A. Background

A provider or supplier whose Medicare enrollment is denied or whose Medicare billing privileges are revoked may request an appeal of that determination. Change of information request denials, reassignment denials, and effective date determinations for initial enrollments may also be appealed.

This appeal process applies to all providers and suppliers - not merely those defined in 42 CFR *Part* 498 - and ensures that all applicants receive a fair and full opportunity to be heard. With the implementation of the appeals provision of Section 936 of the Medicare Prescription Drug Modernization and Improvement Act (MMA), all providers and suppliers that wish to appeal will be given the opportunity to request an appeal of a reconsideration decision to an administrative law judge (ALJ) of the Department of Health and Human Services (DHHS). Providers and suppliers may thereafter seek review by the Departmental Appeals Board (DAB) and may then request judicial review.

B. Notification Letters for Denials and Revocations

If a Medicare contractor finds a legal basis for denying an application - and, if applicable under section 15.8.4 of this chapter, receives approval from the Provider Enrollment *& Oversight* Group (PEOG) for said

denial - the contractor shall deny the application and notify the provider or supplier by letter. The denial letter shall contain:

- A legal (i.e., regulatory) basis for each reason for the denial;
- A clear explanation of why the application is being denied, including the facts or evidence that the contractor used in making its determination;
- An explanation of why the provider or supplier does not meet the applicable enrollment criteria;
- Procedures for submitting a corrective action plan (CAP); and
- Complete and accurate information about the provider or supplier's further appeal rights.

Similarly, when a Medicare contractor discovers a basis for revoking a provider or supplier's *enrollment* - and, if applicable under section 15.27.2 of this chapter, receives approval from PEOG for the revocation - the contractor shall revoke billing privileges and notify the provider or supplier by letter. The revocation letter shall contain:

- A legal (i.e., regulatory) basis for each reason for revocation;
- A clear explanation of why Medicare billing privileges are being revoked, including the facts or evidence that the contractor used in making its determination;
- An explanation of why the provider or supplier does not meet the applicable enrollment criteria;
- The effective date of the revocation (see section 15.27.2(C) of this chapter for more information);
- Procedures for submitting a CAP; and
- Complete and accurate information about the provider or supplier's further appeal rights.

15.25.1.1 – Corrective Action Plans (CAPs)

(Rev. 636, Issued: 02-04-16, Effective: 03-04-16- Implementation: 03-04-16)

A. Requirements and Submission of CAPs

The CAP process gives a supplier an opportunity to correct the deficiencies (if possible) that resulted in the denial of its application or the revocation of its billing privileges. The CAP must:

(1) Contain, at a minimum, verifiable evidence that the supplier is in compliance with Medicare requirements;

(2) Be submitted within 30 days from the date of the denial or revocation notice;

(3) 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;

(4) For revocations, be based on § 424.535(a)(1). Consistent with § 405.809, CAPs for revocations based on grounds other than § 424.535(a)(1) shall not be accepted. (For revocations based on multiple grounds of which one is § 424.535(a)(1), the CAP may be accepted with respect to (a)(1) but not with respect to the other grounds.) If the supplier submits a CAP that does not comply with this paragraph, the contractor shall notify the supplier via letter or e-mail that it cannot be considered. (If multiple grounds are involved of which one is (a)(1), the contractor shall:

- Only consider the portion of the CAP pertaining to (a)(1), and
- Notify the supplier in its decision letter (or, if the contractor wishes, via letter or e-mail prior to issuing the decision letter) that under § 405.809, the CAP was/will be reviewed only with respect to the (a)(1) revocation reason.)

The contractor may create a standard CAP form to be sent with the denial or revocation letter to easily identify it as a CAP when it is returned. The contractor may also accept CAPs via fax or e-mail.

If the submitted CAP does not comply with (1) or (3) above:

- Denials - The contractor need not contact the supplier for the missing information or documentation. It can simply deny the CAP.
- Revocations – The contractor shall not contact the supplier for the missing information or documentation. It shall simply deny the CAP. (Under § 405.809(a)(2), the supplier has only one opportunity to correct all deficiencies that served as the basis of its revocation through a CAP.)

The contractor may make a good cause determination so as to accept any CAP that has been submitted beyond the 30-day filing period.

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 CAP.

B. Processing and Approval of CAPs

The contractor shall process a CAP within 60 days of receipt. During this period, the contractor shall not toll the filing requirements associated with a reconsideration request.

The CAP shall be considered and processed by a contractor staff person who (1) was not involved in the initial decision to deny or revoke enrollment, and (2) is not conducting a concomitant reconsideration of the

provider's or supplier's denial/revocation. In other words, separate individuals must conduct/perform/review the denial/revocation, the CAP, and the reconsideration. This is to ensure completely independent reviews of all three transactions.

If the contractor approves a CAP, it shall rescind the denial or revocation, issue or restore billing privileges (as applicable), and notify the supplier thereof via letter. For new or restored billing privileges – and unless stated otherwise in another CMS directive or instruction - the effective date is based on the date the supplier came into compliance with all Medicare requirements. Consider the following examples:

1. Denials - A physician's initial enrollment application is denied on March 1. The physician submits a CAP showing that, as of March 20, the physician was in compliance with all Medicare requirements. The effective date of billing privileges should be March 20. The 30-day "backbilling rule" should not be applied in this situation because the rule assumes that the provider was in compliance with Medicare requirements during the 30-day period. This was not the case here. The physician was not in compliance with Medicare requirements until March 20.

2. Revocations – A site visit is conducted of a revalidating ambulance supplier. The supplier is found to be out of compliance with certain enrollment requirements. The supplier's billing privileges were therefore revoked effective April 1. The supplier submitted a CAP showing that – as of April 10 – it was in compliance with all enrollment requirements. The contractor shall apply a new effective date of April 10 to the supplier's Provider Transaction Access Number of April 10. Services furnished during the period when the supplier was out of compliance with Medicare requirements shall not be paid.

For an approved CAP, the contractor shall use the receipt date of the CAP 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. CMS' approval is required prior to restoring DMEPOS billing privileges.

C. Concurrent Submission of CAP and Reconsideration Request

If a CAP and a reconsideration request (see section 15.25.1.2 below) are submitted concurrently, the contractor shall first process and make a determination on the CAP. The contractor and the reconsideration hearing officer (HO) shall coordinate with one another prior to acting on a CAP or reconsideration request to determine if the other party has received a request.

If the CAP is accepted, the standard approval letter (or, if applicable, a notice of rescission of the revocation) shall be sent to the supplier with a statement that the reconsideration request should be withdrawn.

If the CAP is denied:

- It *can* be appealed.
- The contractor shall notify the supplier of the denial *and appeal rights* via letter.
- The reconsideration request, if submitted, shall be processed.

15.25.1.2 – Reconsideration Requests – Non-Certified Providers/Suppliers

(Rev. 636, Issued: 02-04-16, Effective: 03-04-16- Implementation: 03-04-16)

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 *hearing officer (*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. *In other words, separate individuals must conduct/perform/review the denial/revocation, the CAP, and the reconsideration. This is to ensure completely independent reviews of all three transactions.*

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.

15.25.2.1 – Corrective Action Plans (CAPs)

(Rev. 636, Issued: 02-04-16, Effective: 03-04-16- Implementation: 03-04-16)

A. Submission of CAPs

The CAP process gives a provider or supplier (hereinafter collectively referred to as "providers") an opportunity to correct the deficiencies (if possible) that resulted in the denial of its application or the revocation of its billing privileges. The CAP must:

(1) Contain, at a minimum, verifiable evidence that the provider is in compliance with Medicare requirements;

(2) Be submitted within 30 days from the date of the denial or revocation notice;

(3) 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.

(4) For revocations, be based on §424.535(a)(1). Consistent with §405.809, CAPs for revocations based on grounds other than §424.535(a)(1) cannot be accepted. (For revocations based on multiple grounds of which one is §424.535(a)(1), the CAP may be accepted with respect to (a)(1) but not with respect to the other grounds.) *CMS'* Provider Enrollment *& Oversight* Group (PEOG), which processes all CAPs, will notify the provider if a CAP cannot be accepted.

CAP requests must be sent to the following address:

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

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

Also:

- PEOG may make a good cause determination so as to accept any CAP that has been submitted beyond the 30-day filing period.

- 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.

B. Processing and Approval of CAPs

PEOG will process a CAP within 60 days. During this period, *PEOG* will not toll the filing requirements associated with a reconsideration request.

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

If *PEOG* denies a CAP, it will notify the provider via letter *(*on which the contractor will be copied*) of the denial and associated appeal rights.*

15.25.2.2 – Reconsideration Requests – Certified Providers and Certified Suppliers

(Rev. 636, Issued: 02-04-16, Effective: 03-04-16- Implementation: 03-04-16)

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 *CMS'* Provider Enrollment *& Oversight* 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.

15.26.1 – HHA Ownership Changes

(Rev. 636, Issued: 02-04-16, Effective: 03-04-16- Implementation: 03-04-16)

A. Background

Effective January 1, 2011, and in accordance with 42 CFR §424.550(b)(1) - if there is a change in majority ownership of an HHA by sale (including asset sales, stock transfers, mergers, and consolidations) within 36 months after the effective date of the HHA's initial enrollment in Medicare or within 36 months after the HHA's most recent change in majority ownership, the provider agreement and Medicare billing privileges do not convey to the new owner. The prospective provider/owner of the HHA must instead:

- Enroll in the Medicare program as a new (initial) HHA under the provisions of §424.510, and
- Obtain a State survey or an accreditation from an approved accreditation organization.

For purposes of §424.550(b)(1), a "change in majority ownership" (as defined in 42 CFR §424.502) occurs when an individual or organization acquires more than a 50 percent direct ownership interest in an HHA during the 36 months following the HHA's initial enrollment into the Medicare program or the 36 months following the HHA's most recent change in majority ownership (including asset sales, stock transfers, mergers, or consolidations). This includes an individual or organization that acquires majority ownership in an HHA through the cumulative effect of asset sales, stock transfers, consolidations, or mergers during the 36-month period after Medicare billing privileges are conveyed or the 36-month period following the HHA's most recent change in majority ownership.

B. Exceptions

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

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

In addition, §424.550(b)(1) does not apply to "indirect" ownership changes.

C. Effective Date

As indicated earlier, the provisions of 42 CFR §424.550(b)(1) and (2) as enacted in "CMS-6010-F, Medicare Program; Home Health Prospective Payment System Rate Update for Calendar Year 2011; Changes in Certification Requirements for Home Health Agencies and Hospices; Final Rule" – are effective January 1, 2011. This means that these provisions impact only those HHA ownership transactions whose effective date is on or after January 1, 2011. However, the provisions can apply irrespective of when the HHA first enrolled in Medicare. Consider the following illustrations:

- Example 1 – Smith HHA initially enrolls in Medicare effective July 1, 2009. Smith undergoes a change in majority ownership effective September 1, 2011. The provisions of §424.550(b)(1) apply to Smith because it underwent a change in majority ownership within 36 months of its initial enrollment.

- Example 2 – Jones HHA initially enrolls in Medicare effective July 1, 2007. Jones undergoes a change in majority ownership effective February 1, 2011. Section 424.550(b)(1) does not apply to this transaction because it occurred more than 36 months after Jones's initial enrollment. Suppose, however, than Jones undergoes another change in majority ownership effective February 1, 2012. Section 424.550(b)(1) would apply to this transaction because it took place within 36 months after Jones's most recent change in majority ownership (i.e., on February 1, 2011).

- Example 3- Johnson HHA initially enrolls in Medicare effective July 1, 2006. It undergoes a change in majority ownership effective October 1, 2010. This transaction is not affected by §424.550(b)(1) – as enacted in CMS-6010-F – because: (1) its effective date was prior to January 1, 2011, and (2) it occurred more than 36 months after the effective date of Johnson's initial enrollment. Johnson undergoes another change in majority ownership effective October 1, 2012. This change would be affected by §424.550(b)(1) because it occurred within 36 months of the HHA's most recent change in majority ownership (i.e., on October 1, 2010).

- Example 4 – Davis HHA initially enrolls in Medicare effective July 1, 1999. It undergoes its first change in majority ownership effective February 1, 2011. This change is not affected by §424.550(b)(1) because it occurred more than 36 months after Davis's initial enrollment. Davis undergoes another change in majority ownership effective July 1, 2014. This change, too, would be unaffected by §424.550(b)(1), as it occurred more than 36 months after the HHA's most recent change in majority ownership (i.e., on February 1, 2011). Davis undergoes another majority ownership change on July 1, 2016. This change would be impacted by §424.550(b)(1), since it occurred within 36 months of the HHA's most recent change in majority ownership (i.e., on July 1, 2014).

D. Section 424.550(b)(1)'s Applicability

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

1. Step 1 – Change in Majority Ownership

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

- The ownership change was a direct ownership change and not a mere indirect ownership change, and

- The change involves a party assuming a greater than 50 percent ownership interest in the HHA.

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

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

2. Step 2 – 36-Month Period

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

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

3. Step 3 – Applicability of Exceptions

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

a. The HHA has submitted 2 consecutive years of full cost reports.

- For purposes of this exception, low utilization or no utilization cost reports do not qualify as full cost reports. As stated in *CMS* Pub. 15-2, Provider Reimbursement Manual, Part 2, section 3204, please refer to 42 CFR §413.24(h) for a definition of low Medicare utilization.

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

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

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

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

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

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

E. Determination

If the contractor concludes that one of the aforementioned exceptions applies *(and unless a CMS instruction or directive states otherwise)*, it may process the application normally. If no exception applies, the contractor shall refer the case to *its PEOG* BFL for review. Under no circumstances shall the contractor take action against the HHA without the prior approval of PEOG. If PEOG agrees with the contractor's

determination, the contractor shall send a letter to the HHA notifying it that, as a result of §424.550(b)(1), the HHA must:

- Enroll as an initial applicant; and

- Obtain a new state survey or accreditation after it has submitted its initial enrollment application and the contractor has made a recommendation for approval to the State/RO.

As the new owner must enroll as a new provider, the contractor shall also deactivate the HHA's billing privileges if the sale has already occurred. If the sale has not occurred, the contractor shall alert the HHA that it must submit a *Form* CMS-855A voluntary termination application.

Providers and/or their representatives (e.g., attorneys, consultants) shall contact their local MAC with any questions concerning (1) the 36-month rule in general and (2) whether the rule and/or its exceptions apply in a particular provider's case.

F. Additional Notes

The contractor is advised of the following:

1. If the contractor learns of an HHA ownership change by means other than the submission of a CMS-855A application, it shall notify its *PEOG BFL* immediately.

2. If the contractor determines, under Step 3 above, that one of the §424.550(b)(2) exceptions applies, the ownership transfer still qualifies as a change in majority ownership for purposes of the 36-month clock. To illustrate, assume that an HHA initially enrolled in Medicare effective July 1, 2010. It undergoes a change in majority ownership effective February 1, 2012. The contractor determined that the transaction was exempt from §424.550(b)(1) because the HHA submitted full cost reports in the previous 2 years. On February 1, 2014, the HHA undergoes another change in majority ownership that did not qualify for an exception. The HHA must enroll as a new HHA under §424.550(b)(1) because the transaction occurred within 36 months of the HHA's most recent change in majority ownership - even though the February 2012 change was exempt from §424.550(b)(1).

15.27.2 – Revocations *(Rev. 636,*

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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' *Provider Enrollment & Oversight Group (PEOG)*.)

When drafting a revocation letter (which, except as described in section 15.27.2(B)(2) below, must be sent to *PEOG* 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 *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 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.

i. The provider or supplier has its provider or supplier agreement involuntarily terminated by the CMS regional office (RO) (as evidenced by a tie-in/tie-out notice, CMS-2007, or other notice from the RO/state).

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 *f*ederal 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 *f*ederal procurement or nonprocurement program or activity in accordance with the FASA implementing regulations and the Department of Health and Human Services nonprocurement common rule at 45 CFR part 76.

If an excluded party is found, the contractor shall notify its *CMS PEOG Business Function Lead (PEOG BFL)* immediately. *PEOG* will notify the Contracting Officer's Representative (COR) for the appropriate 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), *PEOG* -- rather than the contractor -- will (1) make all determinations regarding whether a provider or supplier has a pattern or practice of submitting non-compliant claims; (2) consider the relevant factors; (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 *PEOG'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 *PEOG* Approval

1. Prior *PEOG* 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 *PEOG* via the MACRevocationRequests@cms.hhs.gov mailbox prior to sending the revocation letter. During its review, *PEOG* 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. *PEOG* will notify the contractor of its determinations and instruct the contractor as to how to proceed.

2. Prior *PEOG* Approval Unnecessary

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

- Situation (a), (c), (d), (e), (g), (h), *or (i)* 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 *PEOG* approval) if the provider or supplier submits proof that it has terminated its business relationship with that individual or organization within 30 days of the 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

1. Background

As stated in 42 CFR § 424.535(c), if a provider, supplier, owner, or managing employee has their billing privileges revoked, they are barred from participating in the Medicare program from the effective date of the revocation until the end of the re-enrollment bar. The re-enrollment bar begins 30 days after CMS or its contractor mails notice of the revocation and lasts a minimum of 1 year, but not greater than 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.)

2. Establishment of Length

The following serves merely as general, non-binding guidance regarding the establishment of the length of reenrollment bars. It is crucial to note that every situation must and will be judged on its own merits, facts, and circumstances, and it should not be assumed that a particular timeframe will always be applied to a specific revocation reason in all cases. CMS retains the discretion to apply a reenrollment bar period that is different from that indicated below (though which in no case will be greater than 3 years).

- *§ 424.535(a)(1) (Noncompliance) -- For licensure issues, 1 year if no billing after loss of license; 3 years if billing after loss of license; 3 years for violation of a Medicare policy (using certification statement)*
- *§ 424.535(a)(2) (Provider or Supplier Conduct) – 3 years*
- *§ 424.535(a)(3) (Felonies) – 3 years*
- *§ 424.535(a)(4) (False or Misleading Information) – 3 years*
- *§ 424.535(a)(5) (Onsite Review) – 2 years*
- *§ 424.535(a)(6) (Grounds Related to Screening) – 1 year*
- *§ 424.535(a)(7) (Misuse of Billing Number) – 3 years*
- *§ 424.535(a)(8) (Abuse of Billing) – 3 years*
- *§ 424.535(a)(9) (Failure to Report) - 1 year if licensure, practice location, revocation; 3 years if felony or exclusion*
- *§ 424.535(a)(10) (Failure to Provide CMS Access) – 1 year*
- *§ 424.535(a)(11) (Initial Reserve Operating Funds) – 1 year*
- *§ 424.535(a)(12) (Medicaid Termination) – 2 years*
- *§ 424.535(a)(13) (Prescribing Authority) – 2 years*
- *§ 424.535(a)(14) (Improper Prescribing Practices) – 3 years*

3. Applicability of Bar

In general, and unless stated otherwise above, any re-enrollment bar at a minimum applies to (1) all practice locations under the provider's PECOS or legacy enrollment record, (2) any effort to re-establish any of these locations (i) at a different address, and/or (ii) under a different business or legal identity, structure, or TIN. If the contractor receives an application and is unsure as to whether a revoked provider is attempting to re-

establish a revoked location, it shall contact its *PEOG BFL* for guidance. Instances where the provider might be attempting to do so include - but are not limited to – the following:

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

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

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

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

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 *PEOG* via the ProviderEnrollmentRevocations@cms.hhs.gov mailbox with additional pertinent information regarding the basis for revocation;

- Receiving *PEOG*'s determinations and abiding by *PEOG*'s instructions regarding the case;
- If *PEOG* authorizes the revocation:
  - Revoking the provider's billing privileges back to the appropriate date;
  - Establishing the applicable reenrollment bar;
  - Updating PECOS to show the length of the reenrollment bar;
  - Assessing an overpayment, as applicable; and
  - 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 *PEOG* for certified providers or suppliers, contractors shall access the PEOG appeals log via the Share Point Ensemble site to determine the appeal status to include on the spreadsheet.

Contractors shall submit their completed reports by the 20th of each month to 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:

- E-mail a copy of the revocation letter to the applicable RO's Division of Survey & Certification corporate mailbox. (The RO will notify the state of the revocation.)

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

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

15.27.3 - Other Identified Revocations

(Rev. 636, Issued: 02-04-16, Effective: 03-04-16- Implementation: 03-04-16)

A. Zone Program Integrity Contractor (ZPIC) Identified Revocations

1. General Procedures

If, through its investigations, the ZPIC believes that a particular provider's or supplier's Medicare billing privileges should be revoked, it shall develop a case file - including the reason(s) for revocation - and submit the file and all supporting documentation to the Provider Enrollment *& Oversight* Group (PEOG). The ZPIC shall provide PEOG with the information described in (2) below.

PEOG will review the case file and:

- Return the case file to ZPIC for additional development, or
- Consider approving the ZPIC's recommendation for revocation.

If PEOG approves the revocation recommendation, PEOG will: (1) ensure that the applicable Medicare Administrative Contractor (MAC) is instructed to revoke the provider's/supplier's Medicare *enrollment*, and (2) notify the applicable contracting officer's representative (COR) in the Division of Medicare Integrity Contractor Operations of the action taken.

If the MAC receives a direct request from a ZPIC to revoke a provider's or supplier's Medicare *enrollment*, it shall refer the matter to its PEOG Business Function Lead (*PEOG* BFL) if it is unsure whether the ZPIC received prior PEOG approval for the revocation.

2. Revocation Request Data

The revocation request shall contain the following information:

- Provider/supplier name; practice location(s); type (e.g., DMEPOS supplier); Provider Transaction Access Number; National Provider Identifier; applicable Medicare Administrative Contractor
- Name(s), e-mail address(es), and phone number(s) of investigators
- Tracking number
- Provider/supplier's billing status (Active? Inactive? For how long?)
- Whether the provider/supplier is a Fraud Prevention System provider/supplier
- Source/Special Project
- Whether the provider/supplier is under a current payment suspension
- Legal basis for revocation
- Relevant facts
- Application of facts to revocation reason
- Any other notable facts
- Effective date (per 42 CFR § 424.535(g))

- Supporting documentation

- Photos (which should be copied and pasted within the document)

B. CMS Field Office or Regional Office Identified Revocations

If a CMS field office (SO) or regional office (RO) believes that the use of Revocation Reason 8 (see 42 CFR § 424.535(a)(8) is appropriate), the FO/RO will develop a case file - including the reason(s) for revocation - and submit the file and all supporting documentation to PEOG. The case file must include the name, all known identification numbers - including the National Provider Identifier and associated Provider Transaction Access Numbers - and locations of the provider or supplier, as well as detailed information to substantiate the revocation action.

If PEOG concurs with the FO/RO's revocation recommendation, PEOG will: (1) instruct the contractor to revoke the provider/supplier's Medicare billing privileges, and (2) notify the FO/RO of same.

15.27.4 - External Reporting Requirements

(Rev. 636, Issued: 02-04-16, Effective: 03-04-16- Implementation: 03-04-16)

A. Quarterly

No later than the last day of January, April, July and October of each year, the contractor shall furnish to its *CMS Provider Enrollment & Oversight Group Business Function Lead (PEOG BFL)* via e-mail the following information for the previous quarter:

- Number of revocations of *Form CMS-855A enrollments* and the three most frequent reasons for said *revocations.*

- Number of *revocations of Form CMS-855B and Form CMS-855I enrollments* and the three most frequent reasons therefore. (*Form* CMS-855B and *Form* CMS-855I revocations shall be listed separately.)

The contractor need not submit this data to CMS via any sort of spreadsheet. A simple e-mail is sufficient.

B. Monthly

Using the existing template, the MAC shall capture the following information for all denied Form CMS-855 paper and web applications (to include those entered in PECOS and those not entered in PECOS):

- *LBN of the provider/supplier*
- *NPI*
- *State*
- *Contractor ID*
- *The denial reason (For any applications denied using the 'Other (CMS Only)' reason in PECOS, the MAC shall specify the denial reason in column U)*
- *If the denial was entered in PECOS (Y/N)*

The reports shall be sent to the Provider Enrollment & Operations Group (with a copy to the MAC's Contracting Officer's Representative (COR)) no later than the 15th of each month; the report shall cover the prior month's denials (e.g., the February report shall cover all January denials).

15.29.6 – *Reserved for Future Use*

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