CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-08 Medicare Program Integrity	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 499	**Date: December 27, 2013**
	Change Request 8544

SUBJECT: Update to Chapter 15 of the Program Integrity Manual

I. SUMMARY OF CHANGES: The purpose of this change request (CR) is to update a number of sections in chapter 15 of CMS Publication 100-08 (the Program Integrity Manual, or PIM).

EFFECTIVE DATE: January 28, 2104
IMPLEMENTATION DATE: January 28, 2104

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	15/15/5.3/Final Adverse Actions
R	15/15/5.4.2/Section 4 of the Form CMS-855B
R	15/15/5.13/Contact Persons
R	15/15/5.18/Ambulance Attachment
R	15/15/5.19.5/Supervising Physicians
R	15/15/7.7.1.2/Examining Whether a CHOW May Have Occurred
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	15/15/10.2/Special Instructions for Certified Providers, ASCs, and Portable X-ray Suppliers
R	15/15/24/Model Letter Guidance
R	15/15/27.2/Revocations
R	15/15/27.3/Other Identified Revocations
D	15/15/7.8.2.1/ASC/PXRS Changes of Ownership (CHOWs)
D	15/15/7.8.2.1.1/Determining Whether a CHOW Has Occurred
D	15/15/7.8.2.1.2/EFT Payments and CHOWs
D	15/15/27.2.1/Special Instructions Regarding Revocations of Certified Providers and Certified Suppliers
D	15/15/27.3.1/Zone Program Integrity Contractor (ZPIC) Identified Revocations
D	15/15/27.3.2/CMS Satellite Office or Regional Office Identified Revocations
D	15/15/29.1/Reserved for Future Use
D	15/15/31/Provider Enrollment Fraud Detection Program for High Risk Areas
D	15/15/31.1/Submission of Proposed Implementation Plan for High Risk Areas

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 obliged 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

**Unless otherwise specified, the effective date is the date of service.*

Business Requirements

Pub. 100-08	Transmittal: 498	Date: December 27,, 2013	Change Request: 8544

SUBJECT: Update to Chapter 15 of the Program Integrity Manual

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I. GENERAL INFORMATION

A. Background: The purpose of this change request (CR) is to update a number of sections in chapter 15 of CMS Publication 100-08 (the Program Integrity Manual, or PIM).

B. Policy: This CR updates a number of sections in chapter 15 of the PIM.

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	
8544.1	When referring any final adverse action other than a current exclusion or debarment to the Provider Enrollment Operations Group (PEOG) for review (which shall be done via e-mail or fax), the contractor shall include the following information: (1) provider/supplier name and National Provider Identifier; (2) version of the Form CMS-855 involved; (3) reason for provider/supplier's submission of the application; (4) a summary of the adverse legal facts; and (5) whether the provider/supplier has previously disclosed this or any other final adverse action.	X	X	X						
8544.1.1	If the contractor learns via any means other than the submission of a Form CMS-855 (e.g., from law enforcement, notice from another contractor) that an enrolled provider or supplier has had any final adverse action (regardless of type) imposed against it, the contractor shall refer the matter to its PEOG BFL for guidance.	X	X	X						
8544.2	The contractor shall store all contact persons in the Provider Enrollment, Chain and Ownership System (PECOS); a contact person shall not be removed from PECOS unless the provider requests the removal via letter, e-mail, or fax.	X	X	X						

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
8544.3	If an independent diagnostic testing facility's supervising physician is enrolling in Medicare and does not intend to furnish 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.		X							
8544.4	With respect to the transactions (excluding stock transfers) identified in sections 15.7.7.2(B)(1) and 15.7.8.4(B)(1), if the contractor knows that the particular State/RO in question typically does not review, approve, or deny the transaction in question, the contractor shall follow the instructions in sections 15.7.7.2(B)(2) and 15.7.8.4(B)(2), respectively.	X	X	X						
8544.4.1	For stock transfers involving certified providers and certified suppliers, if the three conditions in sections 15.7.7.2(B)(1) and 15.7.8.4(B)(1) are met, the contractor shall follow the instructions in sections 15.7.7.2(B)(2) and 15.7.8.4(B)(2), respectively.	X	X	X						
8544.5	If the contractor opts to make a recommendation of approval for a new/changed HHA location that has not yet moved or been established, it shall note in its recommendation letter that the HHA location has not yet moved or been established.	X		X						
8544.6	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.	X	X	X						
8544.6.1	In the situations described in business requirement 8544.6, 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.	X	X	X						
8544.7	In sending a revocation request to its contracting officer's representative for forwarding to PEOG, the Zone Program Integrity Contractor (ZPIC) shall ensure that the request contains the data elements specified in section 15.27.3(A)(2).									ZPICs

III. PROVIDER EDUCATION TABLE

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

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information:

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) or Contractor Manager, as applicable.

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 do 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.

Medicare Program Integrity Manual
Chapter 15 - Medicare Enrollment

Table of Contents
(Rev.499, Issued: 12-27-13)

15.5.13 – Contact Persons
15.27.3 – *Other Identified Revocations*

15.5.3 – Final Adverse Actions
(Rev.499, Issued: 12-27-13, Effective: 01- 28-14, Implementation: 01-28-14)

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

- Section 3
- Section 4A of the CMS-855I
- Section 5
- Section 6

A. Disclosure of Final Adverse Action

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

In addition:

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

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

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

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

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

   Example (c) – Company Y is listed as the provider/supplier for two HHAs and 2 suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS). These 4 providers/suppliers are under Y's LBN and TIN. Each provider/supplier is located in a different State. All are enrolled. Y's billing privileges for one of the DMEPOS suppliers are revoked. Y now seeks to enroll an ASC in a fifth State. Y must disclose the DMEPOS revocation on the ASC's initial Form CMS-855, even though the revocation: (1) was done by a Medicare contractor other than that with which the ASC seeks enrollment, and (2) occurred in a State different from that in which the ASC is located.

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

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

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

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

B. Prior Approval

If a current exclusion or debarment is disclosed on the Form CMS-855, the contractor shall deny the application in accordance with the instructions in this chapter; prior approval from PEOG is not necessary. If any other final adverse action is listed, the contractor shall refer the matter to its PEOG BFL for *review. When referring the action to PEOG (which shall be done via e-mail or fax), the contractor shall include the following information: (1) provider/supplier name and National Provider Identifier; (2) version of the Form CMS-855 involved; (3) reason for provider/supplier's submission of the application; (4) a summary of the adverse legal facts; and (5) whether the provider/supplier has previously disclosed this or any other final adverse action.*

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

C. Review of the Provider Enrollment, Chain and Ownership System (PECOS)

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

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

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

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

If the "other provider" is enrolled with a different contractor, the contractor shall notify the latter - via fax or e-mail – of the situation, at which time the latter shall take the revocation action. To illustrate, suppose John Smith attempted to enroll with Contractor X as a physician. Smith is currently listed as an owner of Jones Group Practice, which is enrolled with Contractor Y. Contractor X discovers that Smith was recently

convicted of a felony. X therefore denies Smith's application. X must also notify Y of the felony conviction; Y shall then revoke Jones' billing privileges per 42 CFR § 424.535(a)(3).

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

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

E. *System for Award Management (SAM)*

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

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

15.5.4.2 – Section 4 of the Form CMS-855B

((Rev.499, Issued: 12-27-13, Effective: 01- 28-14, Implementation: 01-28-14)

A. Ambulatory Surgical Centers (ASCs) and Portable X-ray Suppliers

If the applicant's address or telephone number cannot be verified, the contractor shall contact the applicant for further information. If the supplier states that the facility or its phone number is not yet operational, the contractor shall continue processing the application. However, it shall indicate in its recommendation letter that the address and telephone number of the facility could not be verified.

For purposes of PECOS entry, the contractor can temporarily use the date the certification statement was signed as the effective date.

B. Reassignment of Benefits

Per Pub. 100-04, chapter 1, section 30.2.7, a contractor may permit a reassignment of benefits to any eligible entity regardless of where the service was rendered or whether the entity owned or leased that location. As such, the contractor need not verify the entity's ownership or leasing arrangement with respect to the reassignment.

C. Ambulance Companies

If an ambulance company will be furnishing all of its services in the same contractor jurisdiction, the supplier should list:

- Each site at which its vehicles are garaged in section 4A. *(The site is considered a practice location for enrollment purposes, including with respect to payment of the application fee.)*

- Each site from which its personnel are dispatched in section 4A. *(The site is considered a practice location for enrollment purposes, including with respect to payment of the application fee.)*

- Its base of operations – which, for ambulance companies, is their primary headquarters – in section 4E. *(The supplier can only have one base of operations.)*

If the supplier will be furnishing services in more than one contractor jurisdiction, it shall follow the applicable instructions in section 15.5.18 of this chapter.

D. Out-of-State Practice Locations

If a supplier is adding a practice location in another State that is within the contractor's jurisdiction, a separate, initial Form CMS-855B enrollment application is not required if the following 5 conditions are met:

- The location is not part of a separate organization (e.g., a separate corporation, partnership),

- The location does not have a separate tax identification number (TIN) and legal business name (LBN),

- The State in which the new location is being added does not require the location to be surveyed,

- The applicable RO does not require the new location or its owner to sign a separate supplier agreement, and

- The location is not an independent diagnostic testing facility (IDTFs are required to separately enroll each site)

Consider the following examples:

1. The contractor's jurisdiction consists of States X, Y and Z. Jones Group Practice (JGP), Inc., is enrolled in State X with 3 locations. It wants to add a fourth location in State Y. The new location will be under JGP, Inc. JGP will not be establishing a separate corporation, LBN or TIN for the fourth location. Since there is no State or RO involvement with group practices, all 5 conditions are met. JGP can add the fourth location via a change of information request, rather than an initial application. The change request must include all information relevant to the new location (e.g., licensure, new managing employees). To the extent required, the contractor shall create a separate PECOS enrollment record for the State Y location.

2. The contractor's jurisdiction consists of States X, Y and Z. Jones Group Practice (JGP), Inc., is enrolled in State X with 3 locations. It wants to add a fourth location in State Y, but under a newly created, separate entity - Jones Group Practice, LP. The fourth location must be enrolled via a separate, initial Form CMS-855B.

3. The contractor's jurisdiction consists of States X, Y and Z. Jones Group Practice (JGP), Inc., is enrolled in State X with 3 locations. It wants to add a fourth location in State Q. Since State Q is not within the contractor's jurisdiction, a separate initial enrollment for the fourth location is necessary.

4. The contractor's jurisdiction consists of States X, Y and Z. Jones Ambulatory Surgical Center (JASC), Inc., is enrolled in State X with 3 locations. It wants to add a fourth location in State Z under JASC, Inc. However, it has been determined that a separate survey and certification of the new site are required. A separate, initial Form CMS-855B is therefore necessary.

15.5.13 – Contact Person*s*

(Rev.499, Issued: 12-27-13, Effective: 01- 28-14, Implementation: 01-28-14)

The contractor should use *one of* the contact person*s* listed in section 13 of the Form CMS-855 for all communications specifically related to the provider's submission of a Form CMS-855 initial enrollment, change of information request, etc. *(The provider may have as many contact persons as it wishes.)* All other provider enrollment-oriented matters shall be directed to the correspondence address. To illustrate, assume a provider submits an initial Form CMS-855 on March 1. The application is approved on April 15. All communications specifically related to the Form CMS-855 submission between March 1 and April 15 should have been sent to *a* contact person (or, if section 13 is blank, to an authorized/delegated official or the individual physician/practitioner). After April 15, all provider enrollment-oriented correspondence shall go to the correspondence address. Now assume that the provider submits a change of information request on August 1, which the contractor approves on August 30. All communications specifically related to the change request should have gone to *a* contact person between August 1 and August 30.

Notwithstanding the above, all approval/denial letters should be sent to *a* contact person. However, the contractor retains the discretion to send the letter to another address listed on the Form CMS-855 if dictated by circumstances.

In short:

- CMS strongly recommends that all communications (e.g., requests for additional information) specifically related to the submission of a Form CMS-855 (or Form CMS-588) application be

addressed to *a* contact person in section 13. However, the contractor retains the discretion to use the correspondence address if circumstances so warrant.

- All provider enrollment-oriented communications/correspondence not specifically related to a Form CMS-855 (or Form CMS-588) transaction shall be sent to the correspondence address. The contractor has the discretion to determine whether a particular communication is "specifically related" to a Form CMS-855 submission or whether a particular communication is "provider enrollment-oriented."

If the contractor discovers that the contact person qualifies as an owning or managing individual, the provider shall list the person in section 6 of the application.

If multiple contact persons are listed, the contractor has the discretion to select the individual to contact unless the provider indicates otherwise via any means. In addition:

- *The contractor may use multiple contact persons throughout the enrollment process; it need not use the same individual for the entire duration unless, again, the provider indicates otherwise.*

- *All contact persons shall be stored in PECOS and shall not be removed unless the provider requests the removal via letter, e-mail, or fax.*

15.5.18 – Ambulance Attachment

(Rev.499, Issued: 12-27-13, Effective: 01- 28-14, Implementation: 01-28-14)

A. Geographic Area

1. Multiple States

The applicant must list the geographic areas in which it provides services. If the supplier indicates that it provides services:

- *In more than one contractor's jurisdiction, it must submit a separate Form CMS-855B to each contractor.*

- *In more than one state but within the same contractor jurisdiction, the contractor shall review section 15.5.4.2(D) of this chapter to determine whether a separate enrollment for the additional state is required.*

2. Practice Location

For purposes of provider enrollment, the following are considered ambulance "practice locations":

- *A site at which the supplier's vehicles are garaged*

- *A site from which the supplier's personnel are dispatched*

- *The supplier's base of operations (i.e., the supplier's primary headquarters). The supplier can only have one base of operations.*

Hence, if an ambulance supplier submits a Form CMS-855B to add to its enrollment record a site at which the supplier's vehicles are garaged or from which personnel are dispatched, the supplier must pay an application fee.

3. Examples

Consider the following scenarios:

a. <u>The ambulance supplier is enrolling and performing services in multiple states but within only 1 contractor jurisdiction</u>: The supplier would have to list on its Form CMS-855B each city/state/zip code in which it performs services. Its base of operations and all other practice locations would also have to be listed, and all licensure/certification requirements would have to be met for each state in which it performs services. However, separate Form CMS-855B applications for each state would only be required if all 5 conditions described in section 15.5.4.2(D) of this chapter are met. (If separate applications are not required, the contractor shall still create a separate Provider Enrollment, Chain and Ownership System (PECOS) record for each state.)

b. <u>The ambulance supplier is enrolling (and has its base of operations) in Contractor Jurisdiction X. Its vehicles perform services in X and in adjacent Contractor Jurisdiction Y</u>: The supplier would have to enroll with X and Y. For its Contractor X CMS-855B, the supplier would have to list all of the data mentioned in Example (a) above. For its Contractor Y CMS-855B, the supplier would have to (1) list the cities/zip codes in Y in which it performs services, (2) list its Jurisdiction X base of operations and any practice locations in

Jurisdiction Y, and (3) meet all licensure/certification requirements for the state(s) in Y in which the supplier performs services.

B. Licensure Information

With respect to licensure:

- The contractor shall ensure that the supplier is appropriately licensed and/or certified, as *applicable.*

- *A*n air ambulance supplier that is enrolling in a State to which it flies in order to pick up patients (that is, a State other than where its base of operations is located) is not required to have a practice location or place of business in that State. So long as the air ambulance supplier meets all other criteria for enrollment in Medicare, the contractor for that State may not deny the supplier's enrollment application solely on the grounds that the supplier does not have a practice location in that State. (This policy only applies to air ambulance suppliers.)

C. Paramedic Intercept Information

Paramedic intercept services typically involves an arrangement between a basic life support (BLS) ambulance supplier and an advanced life support (ALS) ambulance supplier, whereby the latter provides the ALS services and the BLS supplier provides the transportation component. (See 42 CFR § 410.40 for more information.) If the applicant indicates that it has such an arrangement, it must attach a copy of the agreement/contract.

D. Air Ambulances

Air ambulance suppliers must submit the following:

(1) A written statement signed by the president, chief executive officer, or chief operating officer that gives the name and address of the facility where the aircraft is hangared; and

(2) Proof that the air ambulance supplier or its leasing company possesses a valid charter flight license (FAA Part 135 Certificate) for the aircraft being used as an air ambulance. Any of the following constitutes acceptable proof:

- If the air ambulance supplier or provider owns the aircraft, the owner's name on the FAA Part 135 certificate must be the same as the supplier's or provider’s name on the enrollment application.

- If the air ambulance supplier or provider owns the aircraft but contracts with an air services vendor to supply pilots, training and/or vehicle maintenance, the FAA Part 135 certificate must be issued in the name of the air services vendor. A certification from the supplier or provider must also attest that it has an agreement with the air services vendor and must list the date of that agreement. A copy of the FAA Part 135 Certificate must accompany the enrollment application.

- If the air ambulance supplier or provider leases the aircraft from another entity, a copy of the lease agreement must accompany the enrollment application. The name of the company leasing the aircraft from that other entity must be the same as the supplier's or provider’s name on the enrollment application.

The air ambulance supplier shall maintain all applicable Federal and State licenses and certifications, including pilot certifications, instrument and medical certifications and air worthiness certifications.

In addition:

- The contractor shall access the following FAA Web site on a quarterly basis to validate all licenses/certifications of air ambulance operators that are enrolled with the contractor: http://www.faa.gov/about/office_org/headquarters_offices/agc/operations/agc300/reports

- The contractor shall deny or revoke the enrollment of an air ambulance supplier if the supplier does not maintain its FAA certification or any other applicable licenses.

E. Hospital-Based Ambulances

An ambulance service that is owned and operated by a hospital need not complete a Form CMS-855B if:

- The ambulance services will appear on the hospital's cost-report; and

- The hospital possesses all licenses required by the State or locality to operate the ambulance service.

If the hospital decides to divest itself of the ambulance service, the latter will have to complete a Form CMS-855B if it wishes to bill Medicare.

15.5.19.5 – Supervising Physicians

(Rev.499, Issued: 12-27-13, Effective: 01- 28-14, Implementation: 01-28-14)

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 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.

15.7.7.1.2 - Examining Whether a CHOW May Have Occurred

(Rev.499, Issued: 12-27-13, Effective: 01- 28-14, Implementation: 01-28-14)

As stressed in section 15.7.7.1, the RO – not the contractor – determines whether a CHOW has occurred (unless this function has been delegated). However, in processing the application, the contractor shall perform all necessary background research regarding whether: (1) a CHOW may have occurred, and/or (2) the new owner is accepting assignment of the Medicare assets and liabilities of the old owner. Such research may include reviewing the sales agreement or lease agreement, contacting the provider(s) to request clarification of the sales agreement, etc. (*A* CHOW determination *by the RO* is usually not required prior to the contractor making its recommendation.)

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

In addition:

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

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

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

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

(Rev.499, Issued: 12-27-13, Effective: 01- 28-14, Implementation: 01-28-14)

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 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-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.)

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.499, Issued: 12-27-13, Effective: 01- 28-14, Implementation: 01-28-14)

(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 <u>any</u> 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.

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 State/RO, any inquiry the contractor receives from the supplier 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.

15.10.2 - Special Instructions for Certified Providers, ASCs, and Portable X-ray Suppliers

(Rev.499, Issued: 12-27-13, Effective: 01- 28-14, Implementation: 01-28-14)

A. Timeframe for *Regional Office (RO*) Approval

In situations where RO approval of the change of information is required, it is strongly recommended that the contractor advise the provider that it may take 6 months (or longer) for the request to be approved. The manner and timing in which this information is relayed lies solely within the contractor's discretion.

B. Post-Recommendation Changes

If an applicant submits a change request after the contractor makes a recommendation on the provider's initial CMS-855 application but before the RO issues a tie-in/approval notice, the contractor shall process the newly-submitted data as a separate change of information; it shall not take the changed information/corrected pages and, immediately upon receipt, send them directly to the State/RO to be incorporated into the existing application. The contractor, however, need not enter the change request into *the Provider Enrollment, Chain and Ownership System (PECOS)* until the tie-in notice is issued.

In entering the change request into PECOS, the contractor shall use the date it received the change request in its mailroom as the actual receipt date in PECOS; the date the tie-in notice was issued shall not be used. The contractor shall explain the situation in the "Comments" section in PECOS and in the provider file.

C. Hospital Addition of Practice Location

In situations where a hospital is adding a practice location, the contractor shall notify the provider in writing that its recommendation for approval does not constitute approval of the facility or group as provider-based under 42 CFR § 413.65.

D. Recommendation Before New HHA Location Established

If an HHA is adding a branch or changing the location of its main location or an existing branch, the contractor may make a recommendation for approval to the State/RO prior to the establishment of the new/changed location (notwithstanding any other instruction in this chapter to the contrary). If the contractor opts to make such a recommendation prior to the establishment of the new/changed location, it shall note in its recommendation letter that the HHA location has not yet moved or been established.

15.24 – Model Letter Guidance

(Rev.499, Issued: 12-27-13, Effective: 01- 28-14, Implementation: 01-28-14)

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*: m*onth/dd/yyyy (e.g., January 26, 2012*).*

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

15.27.2 – Revocations

(Rev.499, Issued: 12-27-13, Effective: 01- 28-14, Implementation: 01-28-14)

A. Revocation Reasons

(Except in the situations outlined in section 15.27.2(B) below, the contractor may issue a revocation without prior approval from the Provider Enrollment Operations Group (PEOG).)

When issuing a revocation, the contractor shall insert the appropriate regulatory basis (e.g., 42 CFR §424.535(a)(1)) into its determination 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 described in this section 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.

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 the contractor shall use §424.535(a)(1) as a revocation reason include, but are not limited to, the following:

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

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

c. The provider or supplier is not appropriately licensed.

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

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

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

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

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

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

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

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

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

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

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

If an excluded party is found, the contractor shall notify its PEOG Business Function Lead (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 of the provider or supplier, within the 10 years preceding enrollment or revalidation of enrollment, was convicted of a Federal or State felony offense that CMS has determined to be detrimental to the best interests of the program and its beneficiaries to continue enrollment.

(i) Offenses include—

(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

The CMS determines, upon on-site review, that the provider or supplier is no longer operational to furnish Medicare covered items or services, or is not meeting Medicare enrollment requirements under statute or regulation to supervise treatment of, or to provide Medicare covered items or services for, Medicare patients. Upon on-site review, CMS determines that—

(i) A Medicare Part A provider is no longer operational to furnish Medicare covered items or services, or the provider fails to satisfy any of the Medicare enrollment requirements.

(ii) A Medicare Part B supplier is no longer operational to furnish Medicare covered items or services, or the supplier has failed to satisfy any or all of the Medicare enrollment requirements, or has failed to furnish Medicare covered items or services as required by the statute or regulations.

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

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.

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 revoke the supplier's billing privileges 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 revoke the supplier's billing privileges.

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.

*(M*edicare 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).

See subsection F below for information on a revocation's effect on the provider's other Medicare enrollments.

B. *When Prior PEOG Approval Is Needed*

*P*rior to sending a revocation letter, the contractor shall obtain approval of both the revocation and the revocation letter from its PEOG BFL in the following situations:

- Any revocation, regardless of the reason, involving (1) a provider or supplier that completes a Form-855A application, (2) an ambulatory surgical center, or (3) a portable x-ray supplier.

- A revocation involving a non-certified provider or non-certified supplier that is based on:

  - Situation (b), (c), (d), (e), (f), or (h) under Revocation Reason 1 above, or

  - §424.535(a)(2), (a)(3), (a)(4), (a)(7), (a)(8), (a)(9), (a)(10) and (a)(12).

During this review, CMS will also determine (1) the extent to which the revoked provider or supplier's other locations are affected by the revocation, and (2) the geographic application of the reenrollment bar. (See subsection F below.)

C. Effective Date of Revocations

Per 42 CFR § 405.874(b)(2), a revocation is effective 30 days after CMS or its contractor (including the National Supplier Clearinghouse (NSC)) mails the notice of its determination to the provider or supplier. However, per 42 CFR §424.535(g), 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 PEOG *BFL* 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 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 ultimate discretion to determine whether sufficient "proof" exists.

D. Payment

Per 42 CFR § 405.874(b)(3), Medicare does not pay and a CMS contractor rejects claims for items or services submitted with a service date on or after the effective date of a provider's or supplier's revocation.

E. Re-enrollment Bar

As stated in 42 CFR § 424.535(c), after a provider, supplier, delegated official, or authorized official has had 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. Per §424.535(c), however, the reenrollment bar does not apply if the revocation (1) is based on §424.535(a)(1), <u>and</u> (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 shall be applied.

Unless stated otherwise in this section, the re-enrollment bar is a minimum of 1 year but not greater than 3 years, depending on the severity of the basis for revocation. The contractor shall establish the re-enrollment bar in accordance with the following:

<u>1 year</u> (AR 73) – License revocation/suspension that a deactivated provider (i.e., is enrolled, but is not actively billing) failed to timely report to CMS.

<u>2 years</u> (AR 74) – The provider is no longer operational.

3 years (AR 81) – Medical license revocation/suspension and the practitioner continued to bill Medicare after the license revocation/suspension; felony conviction and the practitioner continued to bill Medicare after the date of the conviction; falsification of information.

For all other revocation reasons, the contractor shall contact its PEOG liaison. PEOG will establish the appropriate enrollment bar for that particular case.

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. The contractor shall not impose a reenrollment bar following a denial of an application.

F. Scope of Revocation and Re-enrollment Bar

The chart below outlines the extent to which (1) a particular revocation generally applies to the provider's other locations and (2) the re-enrollment bar applies.

Revocation Reason	Scope of Revocation	Scope of Bar
§424.535(a)(1)	For situation (a) in Revocation Reason 1, applies to the practice location in question, unless CMS determines otherwise. For situations (b), (c), (d), (e), (f) and (h) in Revocation Reason 1 above, CMS will determine. For situation (g) in Revocation Reason 1, applies to all practice locations under the provider's PECOS or legacy enrollment record, unless CMS determines otherwise.	For situation (a) in Revocation Reason 1- and unless CMS determines otherwise - applies to (1) the practice location in question, and (2) any effort to re-establish that location (i) at a different address and/or (ii) under a different business or legal identity, structure, or tax identification number (TIN). For situations (b), (c), (d), (e), (f) and (h) in Revocation Reason 1, CMS will determine. For situation (g) in Revocation Reason 1- and unless CMS determines otherwise -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.
§424.535(a)(2)	CMS (in consultation, as needed, with the appropriate law enforcement agencies) will determine	CMS (in consultation, as needed, with appropriate law enforcement agencies) will determine
§424.535(a)(3)	CMS will determine	CMS will determine

§424.535(a)(4)	CMS will determine	CMS will determine
§424.535(a)(5)	Applies to the practice location in question, unless CMS determines otherwise. (The specific location should be end-dated if the PECOS record contains other locations that are not being revoked. For instance, if a group practice has three locations – X, Y and Z - and Location X is determined to be non-operational, X should be end-dated; the entire PECOS record should not be placed in a "Revoked" status if Locations Y and Z are not being revoked.)	Unless CMS determines otherwise, applies to (1) the practice location in question, and (2) any effort to re-establish that location (i) at a different address and/or (ii) under a different business or legal identity, structure, or tax identification number (TIN).
§ 424.535(a)(6)	Applies to all practice locations under the provider's PECOS or legacy enrollment record, unless CMS determines otherwise	Unless CMS determines otherwise, -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.
§424.535(a)(7)	CMS will determine	CMS will determine
§424.535(a)(8)	CMS will determine	CMS will determine
§424.535(a)(9)	CMS will determine	CMS will determine
§424.535(a)(10)	CMS will determine	CMS will determine
§424.535(a)(11)	Applies to all practice locations and branches under the revoked HHA's provider agreement, unless CMS determines otherwise.	Unless CMS determines otherwise, applies to (1) all practice locations and branches under the provider's PECOS or legacy enrollment record, (2) any effort to re-establish any of these locations or branches (i) at a different address, and/or (ii) under a different business or legal identity, structure, or TIN.
§424.535(a)(12)	CMS will determine	CMS will determine

Thus, for situations (a) and (g) in Revocation Reason 1 and for revocations under §424.535(a)(5), (a)(6) and (a)(11), the contractor shall apply the revocation and the re-enrollment bar in accordance with this chart. To illustrate, suppose Physician Group X, Inc. enrolled in Medicare in 2009. It has 3 practice locations. One of

the locations has been determined to be non-operational and will be revoked. The contractor shall end-date this location but shall not end-date the other two.

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 by no means 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.

G. Submission of Claims for Services Furnished Before Revocation

Per 42 CFR § 424.535(g), any physician, physician assistants, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse-midwife, clinical social worker, clinical psychologist, registered dietitian or nutrition professional, organization (e.g., group practices) consisting of any of the categories of individuals identified in this paragraph, or IDTF who/that is revoked from the Medicare program must, within 60 calendar of the effective date of the revocation, submit all claims for items and services furnished.

H. *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.

I. Notification to Other Contractors

If the contractor revokes a provider or supplier's Medicare billing privileges, the contractor shall determine, via a search of PECOS, whether the provider/supplier is enrolled with any other Medicare contractors. If the contractor determines that the revoked provider/supplier is indeed enrolled with another contractor(s), the revoking contractor shall notify these other contractors of the revocation. The notification shall be done via e-mail and shall contain a short description of the reason for the revocation.

Upon receipt of this notification from the revoking contractor, the receiving contractor shall determine whether the provider or supplier's billing privileges should be revoked in its jurisdiction as well. This may require that the contractor contact its PEOG BFL for guidance per the instructions in this chapter.

J. Provider Enrollment Appeals Process

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

K. 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:

- Revoking the provider's billing privileges back to the appropriate date;
- Establishment of the applicable reenrollment bar;
- Updating PECOS to show the length of the reenrollment bar;
- Assessment of an overpayment, as applicable;
- Providing PEOG with the amount of the assessed overpayment within 10 days of the overpayment assessment; and
- Affording appeal rights.

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

Contractors shall be required to update the last three columns on the tab named "Filtered Revocations" of the spreadsheet for every provider/supplier revocation or denial action taken. Contractors 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 appeal's log via the Share Point Ensemble site to determine the appeal status to include on the spreadsheet.

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

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

Contractors 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.499, Issued: 12-27-13, Effective: 01- 28-14, Implementation: 01-28-14)

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 Operations 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
- *C*onsider 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 billing privileges, 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 billing privileges, it shall refer the matter to its PEOG Business Function Lead (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.