CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 471	**Date: June 11, 2013**
	Change Request 8222

Transmittal 461, dated April 26, 2013, is being rescinded and replaced by Transmittal 471, dated June 11, 2013 to remove duplicative language at the end of section 15.5.4(C) of chapter 15. All other information remains the same.

SUBJECT: Update to Chapter 15 of the Program Integrity Manual (PIM)

I. SUMMARY OF CHANGES: The purpose of this change request (CR) is to incorporate several recent policy clarifications into CMS Publication 100-08, chapter 15.

EFFECTIVE DATE: May 28, 2013
IMPLEMENTATION DATE: May 28, 2013

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	15/15.4.4.6/Clinical Psychologists
R	15/15.5.4/Practice Location Information
R	15/15.19.2.5/ Movement of Providers and Suppliers into the High Level
R	15/15.25.1.2/Reconsideration Requests
R	15/15.25.2.2/Reconsideration Requests

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractor's activities are to be carried out within their operating budgets.

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.*

Attachment - Business Requirements

Pub. 100-08	Transmittal: 471	Date: June 11, 2013	Change Request: 8222

Transmittal 461, dated April 26, 2013, is being rescinded and replaced by Transmittal 471, dated June 11, 2103 to remove duplicative language at the end of section 15.5.4(C) of chapter 15. All other information remains the same.

SUBJECT: Update to Chapter 15 of the Program Integrity Manual (PIM)

EFFECTIVE DATE: May 28, 2013
IMPLEMENTATION DATE: May 28, 2013

I. GENERAL INFORMATION

A. Background: The purpose of this change request (CR) is to incorporate several recent policy clarifications into CMS Publication 100-08, chapter 15.

B. Policy: This CR incorporates various recent policy clarifications into chapter 15 of the PIM.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
8222.1	**NOTE**: The contractor shall observe the policy clarifications outlined in this change request.	X	X		X	X	X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility						
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Other
		Part A	Part B					

Number	Requirement	Responsibility						
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Other
		Part A	Part B					
8222.2	MLN Article : A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.							

IV. SUPPORTING INFORMATION

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

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): Frank Whelan, 410-786-1302 or frank.whelan@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Carriers:

No additional funding will be provided by CMS; Contractor's activities are to be carried out within their operating budgets.

Section B: 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.

15.4.4.6 - Clinical Psychologists

(Rev.471, Issued: 06-11-13, Effective: 05 -28- 13, Implementation: 05-28-13)

Under 42 CFR § 410.71(d), to qualify as a clinical psychologist a practitioner must meet the following requirements:

- Hold a doctoral degree in psychology *(that is, a Ph.D., Ed.D., Psy.D.),* and
- Be licensed or certified on the basis of the doctoral degree in psychology by the State in which he or she practices, at the independent practice level of psychology, to furnish diagnostic, assessment, preventive, and therapeutic services directly to individuals.

A clinical psychologist must agree to meet the consultation requirements of 42 CFR §410.71(e)(1) through (e)(3). Under 42 CFR § 410.71(e), the practitioner's signing of the Form CMS-855I indicates his or her agreement.

For more information on clinical psychologists, refer to:

- Pub. 100-04, chapter 12, sections 170 (Claims Processing Manual)
- Pub. 100-02, chapter 15, section 160 (Benefit Policy Manual)

15.5.4 – Practice Location Information

Rev4.71, Issued: 06-11-13, Effective: 05 -28- 13, Implementation: 05-28-13)

Unless specifically indicated otherwise, the instructions in this section 15.5.4 apply to the *Form* CMS-855A, the *Form* CMS-855B, and the *Form* CMS-855I.

The instructions in section 15.5.4.1 apply only to the *Form* CMS-855A; the instructions in section 15.5.4.2 apply only to the *Form* CMS-855B; and the instructions in section 15.5.4.3 only apply to the *Form* CMS-855I.

A. Practice Location Verification

The contractor shall verify that the practice locations listed on the application actually exist. ***(Note***: *T*he practice location name may be the "doing business as" name.*)* If a particular location cannot at first be verified, the contractor shall request clarifying information. (For instance, the contractor can request that the applicant furnish letterhead showing the appropriate address.)

The contractor shall also verify that the reported telephone number is operational and connects to the practice location/business listed on the application. (The telephone number must be one where patients and/or customers can reach the applicant to ask questions or register complaints.) The contractor shall match the applicant's telephone number with known, in-service telephone numbers - via, for instance, the Yellow Pages or the Internet - to correlate telephone numbers with addresses. If the applicant uses his/her/its cell phone for their business, the contractor shall verify that this is a telephone connected directly to the business. If the contractor cannot verify the telephone number, it shall request clarifying information from the applicant; the inability to confirm a telephone number may indicate that an onsite visit is necessary. In some instances, a 1-800 number or out-of-state number may be acceptable if the applicant's business location is in another State but his/her/its practice locations are within the contractor's jurisdiction.

In addition:

- If an individual practitioner or group practice: (1) is adding a practice location and (2) is normally required to complete a questionnaire in section 2 of the *Form* CMS-855I or *Form* CMS-855B specific to its

supplier type (e.g., psychologists, physical therapists), the person or entity must submit an updated questionnaire to incorporate services rendered at the new location.

- Any provider submitting a *Form* CMS-855A, *Form* CMS-855B or *Form* CMS-855I application must submit the 9-digit ZIP Code for each practice location listed.

B. Do Not Forward (DNF)

Unless instructed otherwise in another CMS directive, the contractor shall follow the DNF initiative instructions in Pub. 100-04, chapter 1, section 80.5. Returned paper checks, remittance notices, or EFT payments shall be flagged if returned from the post office or banking institution, respectively, as this may indicate that the provider's "special payment" address (section 4 of the *Form* CMS-855) or EFT information has changed. The provider should submit a *Form* CMS-855 or *Form* CMS-588 request to change this address; if the provider does not have an established enrollment record in *the Provider Enrollment, Chain and Ownership System,* it must complete an entire *Form CMS-855 and Form CMS-588. The Durable Medical Equipment Medicare Administrative Contractors* are responsible for obtaining, updating and processing *Form* CMS-588 changes.

In situations where a provider is closing his/her/its business and has a termination date (e.g., he/she is retiring), the contractor will likely need to make payments for prior services rendered. Since the practice location has been terminated, the contractor may encounter a DNF message. If so, the contractor should request the provider to complete the "special payment" address section of the *Form* CMS-855 and to sign the certification statement. The contractor, however, shall not collect any other information unless there is a need to do so.

C. Remittance Notices/Special Payments

For new enrollees, all payments must be made via EFT. The contractor shall thus ensure that the provider has completed and signed the *Form* CMS-58*8* and shall verify that the bank account is in compliance with Pub. 100-04, chapter 1, section 30.2.

If an enrolled provider that currently receives paper checks submits a *Form* CMS-855 change request – no matter what the change involves – the provider must <u>also</u> submit:

- A *Form* CMS-588 that switches its payment mechanism to EFT. (The change request cannot be processed until the *Form* CMS-588 is submitted.) All future payments (excluding special payments) must be made via EFT.

- An updated section 4 that identifies the provider's desired "special payments" address.

The contractor shall also verify that the bank account is in compliance with Pub. 100-04, chapter 1, section 30.2.

(Once a provider changes its method of payment from paper checks to EFT, it must continue using EFT. A provider cannot switch from EFT to paper checks.)

The "special payment" address may only be one of the following:

- One of the provider's practice locations

- A P.O. Box

- The provider's billing agent. The contractor shall request additional information if it has any reason to suspect that the arrangement – at least with respect to any special payments that might be made – may violate the Payment to Agent rules in Pub. 100-04, chapter 1, section 30.2.

- The chain home office address. Per Pub.100-04, chapter 1, section 30.2, a chain organization may have payments to its providers sent to the chain home office. The legal business *name of* the chain home office must be listed on the *Form* CMS-588. *The TIN on the Form CMS-588 should be that of the provider.*

- Correspondence address

15.19.2.5 – Movement of Providers and Suppliers into the High Level

Rev.471, Issued: 06-11-13, Effective: 05 -28- 13, Implementation: 05-28-13)

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

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

2. The provider or supplier:

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

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

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

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

   d. Has been excluded from any Federal health care program

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

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

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

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

15.25.1.2 – Reconsideration Requests

(Rev Rev.471, Issued: 06-11-13, Effective: 05 -28- 13, Implementation: 05-28-13)

A. Timeframe for Submission

A supplier that wishes to request a reconsideration must file its request in writing with the Medicare contractor within 60 days after the postmark date of the denial or revocation notice to be considered timely filed. The contractor shall extend the filing period an additional 5 days to allow for mail time. A reconsideration request submitted on the 65th day that falls on a weekend or holiday shall still be considered timely filed. The date on which the contractor receives the request is considered to be the date of filing.

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

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

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

B. Signatures

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

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

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

C. Contractor's Receipt of Reconsideration Request

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

D. Reconsideration Determination

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

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

- *The initial determination itself,*

- *The findings on which the initial determination was based,*

- *The evidence considered in making the initial determination, and*

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

Although the contractor, like the provider or supplier, may submit new evidence, it may not introduce new denial or revocation reasons or change a denial or revocation reason listed in the initial determination during the reconsideration process.

E. Issuance of Reconsideration Decision

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

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

- A summary of the documentation that the supplier provided;

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

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

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

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

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

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

F. Withdrawal of Reconsideration Request

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

G. Reports

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

15.25.2.2 – Reconsideration Requests

(Rev.471, Issued: 06-11-13, Effective: 05 -28- 13, Implementation: 05-28-13)

A. Timeframe for Submission

A provider that wishes to request a reconsideration must submit its request, in writing, to the Provider Enrollment Operations Group (PEOG) within 60 days after the postmark date of the denial or revocation notice to be considered timely filed. The mailing address is:

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

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

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

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

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

B. Signatures

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

C. Receipt of Reconsideration Request

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

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

D. Reconsideration Determination

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

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

- *The initial determination itself,*
- *The findings on which the initial determination was based,*
- *The evidence considered in making the initial determination, and*
- *Any other written evidence submitted under § 498.24(a), taking into account facts relating to the status of the provider or supplier subsequent to the initial determination.*

Although the contractor, like the provider or supplier, may submit new evidence, it may not introduce new denial or revocation reasons or change a denial or revocation reason listed in the initial determination during the reconsideration process.

E. Issuance of Reconsideration Decision

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

- The re-stated facts and findings, including the regulatory basis for the action as determined by the contractor in its initial determination;
- A summary of the documentation that the provider furnished;
- A clear explanation of why PEOG is upholding or overturning the denial or revocation action in sufficient detail for the provider to understand PEOG's decision and, if applicable, the nature of the provider's deficiencies;
- If applicable, the regulatory basis to support each reason for the denial or revocation;
- If applicable, an explanation of how the provider does not meet the enrollment criteria or requirements;
- Further appeal rights, procedures for requesting an administrative law judge (ALJ) hearing, and the address to which the written appeal must be mailed or e-mailed; and
- Information that the provider must include with its appeal (name/legal business name; supplier number (if applicable); tax identification number/employer identification number (TIN/EIN); and a copy of the reconsideration decision).

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

F. Withdrawal of Reconsideration Request

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