CMS Manual System	Department of Health & Human Services
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services
Transmittal 296	Date: JULY 10, 2009
	Change Request 6499

SUBJECT: Provider Enrollment Verification Activities

I. SUMMARY OF CHANGES: This change request furnishes clarification on the mechanisms by which contractors shall verify data on the CMS-855 application.

NEW / REVISED MATERIAL
EFFECTIVE DATE: August 10, 2009
IMPLEMENTATION DATE: August 10, 2009

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	10/Table of Contents
R	10/4.2.1/Employer Identification Numbers and Legal Business Names
R	10/4.2.6/Section 2 of the CMS-855B
R	10/4.2.7/Section 2 of the CMS-855I
R	10/4.3/Adverse Legal Actions/Convictions
R	10/4.4/Practice Location Information
R	10/4.5/Owning and Managing Organizations
R	10/4.8/Billing Agencies
N	10/4.21.1/NPI-Legacy Combinations
R	10/5.2/Verification of Data
R	10/12.2.7/Suppliers of Ambulance Services
D	10/12.2.8/Suppliers of Ambulance Services

III. FUNDING:

SECTION A: For Fiscal Intermediaries and Carriers:

No additional funding will be provided by CMS; contractor 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 does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

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

Attachment - Business Requirements

Pub. 100-08	Transmittal: 296	Date: July 10, 2009	Change Request: 6499

SUBJECT: Provider Enrollment Verification Activities

Effective Date: August 10, 2009
Implementation Date: August 10, 2009

I. GENERAL INFORMATION

A. Background: This change request furnishes clarification on the mechanisms by which contractors shall verify certain data on the CMS-855 application.

B. Policy: The purpose of this change request is to provide clarification on the aforementioned subject.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6499.1	For CMS-855B and CMS-855I applications, the contractor shall verify the supplier's licensure status by reviewing State licensure Web sites, contacting State licensing boards, etc. (Only in exceptional circumstances should the contractor request licensure documentation from the provider.)	X			X						
6499.2	In accordance with Pub. 100-08, chapter 10, section 4.2.6, if a PT/OT group answers "yes" to question 2, 3, 4, or 5 in Section 2(E) of the CMS-855B, the contractor shall request a copy of the lease agreement giving the group exclusive use of the facilities for PT/OT services only if it has reason to question the accuracy of the group's response.	X			X						
6499.3	In accordance with Pub. 100-08, chapter 10, section 4.2.7, the contractor shall - to the maximum extent possible - use means other than a practitioner's submission of documentation to validate his or her educational qualifications.	X			X						
6499.4	In accordance with Pub. 100-08, chapter 10, section 4.21.1, if a Medicare contractor determines that a provider is having claim payment issues due to an incorrect NPI-Provider Transaction Access Number (PTAN) combination or NPI-CCN combination entered	X		X	X	X					

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	into PECOS in or after May 2006, the contractor shall request that the provider submit the correct NPI-legacy combination via a CMS-855 change of information.										

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	None										

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: For all other recommendations and supporting information, use this space:

V. CONTACTS

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

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 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 does not construe this as a change to the MAC Statement of Work. The contractor is not

obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Medicare Program Integrity Manual
Chapter 10 - Medicare Provider/Supplier Enrollment

Table of Contents
(Rev. 296, 07-10-09)

4.2.1 – Employer Identification Numbers and Legal Business Names

(Rev. 296; Issued: 07-10-09; Effective/Implementation Date: 08-10-09)

A. Employer Identification Numbers

Sections 1124 and 1124A of the Social Security Act require that Medicare applicants furnish their tax identification number (TIN), as well as the TINs of all entities and persons listed in sections 5 and 6, respectively, of the CMS-855. The TIN can either be an employer identification number (EIN) or a social security number *(SSN).*

If the contractor determines that the provider's EIN may be incorrect, it shall request that the provider clarify the discrepancy (e.g., submission of an IRS CP-575 form). If the discrepancy cannot be resolved, the contractor shall deny the application.

B. *Owners and Managers*

All instances described in this section 4.2.1 in which the contractor should deny the application also apply to owners, managers, etc., not just the applicant.

C. *Certified Providers*

There is no prohibition against two or more certified providers having the same TIN (e.g., a company may own four HHAs, all of which are under the company's TIN.) However, each *provider* must enroll separately.

4.2.6 – Section 2 of the CMS-855B

(Rev. 296; Issued: 07-10-09; Effective/Implementation Date: 08-10-09)

Any supplier that indicates it is an OT/PT group must complete the questionnaire in section 2E. In doing so:

- If the group indicates that it renders services in patients' homes, the contractor shall verify that the group has an established private practice where it can be contacted directly and where it maintains patients' records.

- If the group answers "yes" to question 2, 3, 4, or 5, *the contractor shall request a copy of the lease agreement giving the group exclusive use of the facilities for PT/OT services only if it has reason to question the accuracy of the group's response. If the contractor makes this request and the provider cannot furnish a copy of the lease, the contractor shall deny the application.*

4.2.7 – Section 2 of the CMS-855I

(Rev. 296; Issued: 07-10-09; Effective/Implementation Date: 08-10-09)

A. Specialties

On the CMS-855I, the physician must indicate his/her supplier specialties, showing "P" for primary and "S" for secondary. Non-physician practitioners must indicate their supplier type.

The contractor shall deny the application if the individual fails to meet the requirements of his/her physician specialty or supplier type.

B. Education for Non-Physician Practitioners

The contractor shall verify all required educational information for non-physician practitioners. *While the* non-physician practitioner must meet all Federal and State requirements, *he/she need not* provide documentation of courses or degrees taken to satisfy *these requirements unless specifically requested to do so by the contractor. To the maximum extent possible, the contractor shall use means other than the practitioner's submission of documentation- such as a State or school Web site - to validate the person's educational qualifications.*

A physician need not submit a copy of his/her degree *unless specifically requested to do so by the contractor. To the maximum extent possible, the contractor shall use means other than the physician's submission of documentation- such as a State or school Web site - to validate the person's educational status.*

C. Resident/Intern Status

If the applicant is a "resident" in an "approved medical residency program" (as these two terms are defined at 42 CFR §413.75(b)), the contractor shall refer to Pub. 100-02, chapter 15, section

30.3 for further instructions. (The contractor may also want to refer to 42 CFR §415.200, which states that services furnished by residents in approved programs are not "physician services.")

Note that an intern cannot enroll in the Medicare program. (For purposes of this requirement, the term "intern" means an individual who is not licensed by the State because he/she is still in post-graduate year (PGY) 1.) Also, an individual in a residency or fellowship program cannot be reimbursed for services performed as part of that program. Thus, if the person indicates that all of his/her services will be furnished within that program, he/she cannot be enrolled.

D. Physician Assistants

As stated in the instructions on page 3 of the CMS-855I, physician assistants (PAs) who are enrolling in Medicare need only complete sections 1, 2, 3, 13, 15, and 17 of the CMS- 855I. The physician assistant must furnish his/her NPI in section 1 of the application, and must list his/her employers in section 2E.

The contractor must verify that the employers listed are: (1) enrolled in Medicare, and (2) not excluded or debarred from the Medicare program. (An employer can only receive payment for a PA's services if both are enrolled in Medicare.) All employers must also have an established record in PECOS. If an employer is excluded or debarred, the contractor shall deny the application.

Since PAs cannot reassign their benefits – even though they are reimbursed through their employer – they should not complete a CMS-855R.

E. Psychologists Billing Independently

The contractor shall ensure that all persons who check "Psychologist Billing Independently" in section 2D2 of the CMS-855I answer all questions in section 2I. If the supplier answers "no" to question 1, 2, 3, 4a, or 4b, the contractor shall deny the application.

F. Occupational/Physical Therapist in Private Practice (OT/PT)

All OT/PTs in private practice must respond to the questions in section 2J of the CMS-855I. If the OT/PT plans to provide his/her services as: (1) a member of an established OT/PT group, (2) an employee of a physician-directed group, or (3) an employee of a non-professional corporation, and that person wishes to reassign his/her benefits to that group, this section does not apply. Such information will be captured on the group's CMS-855B application.

If the OT/PT checks that he/she renders all of his/her services in patients' homes, the contractor shall verify that he/she has an established private practice where he/she can be contacted directly and where he/she maintains patient records. (This can be the person's home address, though all Medicare rules and instructions regarding the maintenance of patient records apply.) In addition, section 4D of the CMS-855I should indicate where services are rendered (e.g., county, State, city of the patients' homes). Post office boxes are not acceptable.

If the individual answers "yes" to question 2, 3, 4, or 5, the contractor shall request a copy of the lease agreement giving him/her exclusive use of the facilities for PT/OT services only if it has reason to question the accuracy of his/her response. If the contractor makes this request and the provider cannot furnish a copy of the lease, the contractor shall deny the application.

4.3 – Adverse Legal Actions/Convictions

(Rev. 296; Issued: 07-10-09; Effective/Implementation Date: 08-10-09)

Unless stated otherwise, the instructions in this section 4.3 apply to the following sections of the CMS-855 application:

- Section 3
- Section 4A of the CMS-855I
- Section 5B (Owning and Managing Organizations)
- Section 6B (Owning and Managing Individuals)

If the applicant indicates that a felony or misdemeanor conviction has been imposed against a person or entity listed on the CMS-855, the contractor shall refer the matter to its DPSE contractor liaison for further instructions. (CMS may refer the matter to the OIG or Program Safeguard Contractor (PSC) or Zone Program Integrity Contractor (ZPIC), if necessary.) In its referral to CMS, the contractor shall furnish a brief explanation of the matter along with the applicable section of the CMS-855 (e.g., section 3, section 5). The contractor shall neither approve nor deny the application until DPSE issues a final directive to the contractor.

If the applicant is excluded or debarred, the contractor shall deny the application in accordance with the instructions in this manual; prior approval from DPSE is not necessary. If any other adverse action is listed, the contractor shall refer the matter to its DPSE contractor liaison for instructions.

The applicant shall 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. It is extremely important that the contractor obtain such documentation, regardless of whether the adverse action occurred in a State different from that in which the provider currently seeks enrollment. (In other words, all adverse actions must be fully disclosed, irrespective of where the action took place.) In situations where the person or entity in question was excluded but has since been reinstated, the contractor shall verify this through the OIG and ask the applicant to submit written proof (e.g., reinstatement letter) that such reinstatement has in fact taken place.

If the applicant states in section 3, 4A of the CMS-855I, 5, and/or 6 that the person or entity in question has never had an adverse legal action imposed against him/her/it but *there is evidence to indicate* otherwise, the contractor shall contact DPSE for further instructions. The contractor

shall neither approve nor deny the application until DPSE issues a final directive, which could include an instruction to deny the application based on false information furnished by the applicant. (See section 6.2 of this manual for further details on the handling of potentially falsified applications.)

If the contractor denies an application or revokes a provider based on an adverse legal action, the contactor shall search PECOS (or, if the provider is not in PECOS, the contractor's internal systems) to determine: (1) whether the provider has any other associations (e.g., is listed in PECOS as an owner of three Medicare-enrolled providers), or (2) 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).

Chain Home Offices, Billing Agencies, and HHA Nursing Registries

If the contractor discovers that an entity listed in sections 7, 8, or 12 of the CMS 855 *has had a final adverse action imposed against it*, the contractor shall handle the matter in accordance with the instructions in this section 4.3.

4.4 – Practice Location Information

(Rev. 296; Issued: 07-10-09; Effective/Implementation Date: 08-10-09)

Unless specifically indicated otherwise, the instructions in this section 4.4 apply to the CMS-855A, the CMS-855B, and the CMS-855I.

The instructions in section 4.4.1 apply only to the CMS-855A; the instructions in section 4.4.2 apply only to the CMS-855B; and the instructions in section 4.4.3 only apply to the CMS-855I.

A. Practice Location Verification

The contractor shall *verify that* the practice locations listed on the application actually exist; note that the 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 CMS-855I or 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 CMS-855A, CMS-855B or CMS-855I application must submit the 9-digit ZIP Code for each practice location listed.

B. Do Not Forward (DNF)

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 CMS-855) or EFT information has changed. The provider should submit a CMS-855 or CMS-588 request to change this address; if the provider does not have an established enrollment record in PECOS, it must complete an entire CMS-855 application and CMS-588 EFT form. The DME MACs are responsible for obtaining, updating and processing 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 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 CMS-588, 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 CMS-855 change request – no matter what the change involves – the provider must also submit:

- A CMS-588 that switches its payment mechanism to EFT. (The change request cannot be processed until the 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 and TIN of the chain home office must be listed on the CMS-588.

- Correspondence address

4.5 – Owning and Managing Organizations

(Rev. 296; Issued: 07-10-09; Effective/Implementation Date: 08-10-09)

(This section only applies to section 5 of the CMS-855A and CMS-855B. It does not apply to the CMS-855I.)

All organizations that have any of the following must be listed in section 5A of the CMS-855:

1. A 5 percent or greater direct or indirect ownership interest in the provider.

The following illustrates the difference between direct and indirect ownership:

EXAMPLE: The supplier listed in section 2 of the CMS-855B is an ambulance company that is wholly (100 percent) owned by Company A. Company A is considered to be a direct owner of

the supplier (the ambulance company), in that it actually owns the assets of the business. Now assume that Company B owns 100 percent of Company A. Company B is considered an indirect owner - but an owner, nevertheless - of the supplier. In other words, a direct owner has an actual ownership interest in the supplier, whereas an indirect owner has an ownership interest in an organization that owns the supplier.

For purposes of enrollment, ownership also includes "financial control." Financial control exists when:

(a) An organization or individual is the owner of a whole or part interest in any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by the provider or any of the property or assets of the provider, and

(b) The interest is equal to or exceeds 5 percent of the total property and assets of the provider.

2. A partnership interest in the provider, regardless of: (1) the percentage of ownership the partner has, and (2) whether the partnership interest is that of a general partner or limited partner (e.g., all limited partners in a limited partnership must be listed in section 5A).

3. Managing control of the provider.

A managing organization is one that exercises operational or managerial control over the provider, or conducts the day-to-day operations of the provider. The organization need not have an ownership interest in the provider in order to qualify as a managing organization. For instance, the entity could be a management services organization under contract with the provider to furnish management services for one of the provider's practice locations.

Contractors shall also note the following with respect to owning and managing organizations:

- Such organizations generally fall into one of the following categories: (1) corporations (including non-profit corporations); (2) partnerships and limited partnerships; (3) limited liability companies; (4) charitable and religious organizations; (5) governmental/tribal organizations.

- Any entity listed as the applicant in section 2 of the CMS-855 need not be reported in section 5A. The only exception to this involves governmental entities, which must be listed in section 5A even if they are already listed in section 2.

- With respect to governmental organizations, the letter referred to in the CMS-855 form instructions for section 5 must be signed by an appointed or elected official of the governmental entity who has the authority to legally and financially bind the government to the laws, regulations, and program instructions of Medicare. There is no requirement that this government official also be an authorized official, or vice versa.

- Many non-profit organizations are charitable or religious in nature, and are operated and/or managed by a Board of Trustees or other governing body. The actual name of the Board of Trustees or other governing body should be listed in section 5A of the CMS-855. The applicant should submit a copy of its 501(c)(3) approval notification for non-profit status. If it does not possess such documentation but nevertheless claims it is a non-profit entity, the applicant may submit any other documentation that supports its claim, such as written documentation from the State, etc. This documentation is necessary if the applicant does not list any owners in section 5 or section 6 of the application.

- Owning/managing organizations need not submit an IRS CP-575 document unless requested by the contractor (e.g., the contractor discovers a potential discrepancy between the organization's legal business name and tax identification *number.)*

- *If the organization in section 5, has adverse legal history, the contractor shall follow the instructions in section 4.3 of this chapter.*

4.8 – Billing Agencies

(Rev. 296; Issued: 07-10-09; Effective/Implementation Date: 08-10-09)

(This section applies to the CMS-855A, the CMS-855B, and the CMS-855I.)

The provider shall complete this section with information about any and all billing agents that prepare and submit claims on its behalf. As all Medicare payments must be made via EFT, the contractor no longer needs to verify the provider's compliance with the "Payment to Agent" rules in Pub. 100-04, chapter 1, section 30.2. The only exception to this is if the contractor discovers that the "special payments" address in section 4 of the provider's application belongs to the billing agent. In this situation, the contractor may obtain a copy of the billing agreement if it has reason to believe that the arrangement violates the "Payment to Agent" rules.

If the chain organization listed in section 7 of the CMS-855A also serves as the provider's billing agent, the chain must be listed in section 8 as well.

4.21.1 – NPI-Legacy Combinations

(Rev. 296; Issued: 07-10-09; Effective/Implementation Date: 08-10-09)

If a Medicare contractor determines that a provider is having claim payment issues due to an incorrect NPI-Provider Transaction Access Number (PTAN) combination or NPI-CCN combination entered into PECOS in or after May 2006, the contractor shall request that the provider submit the correct NPI-legacy combination via a CMS-855 change of information. The change request can be faxed and the contractor can initiate the change and commence the work without receiving the original application and signature by mail. The contractor shall verify the faxed signature against the applicant's or authorized official's signature on file, before any changes are made in PECOS.

The contractor shall not use this process to resolve any other enrollment issue other than the correction of the NPI-legacy identifier combination. Moreover, the contractor shall not use this process for providers who have not submitted a complete CMS-855 enrollment application at any time during or after May 2006. For instance, assume a provider first enrolled in Medicare in December 2005 and has not submitted a complete enrollment application after that date. The provider would be unable to utilize the process described in the previous paragraph.

5.2 – Verification of Data

(Rev. 296; Issued: 07-10-09; Effective/Implementation Date: 08-10-09)

The general purpose of the verification process is to determine if any of the data furnished on the CMS-855 *is incorrect.* The contractor may begin the verification process at any time, including during the prescreening phase.

A. Concurrent Reviews

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

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

B. *Mechanisms of Verification*

Unless stated otherwise in this manual or in other CMS directives (e.g., JSMs), the contractor shall verify all data furnished on the CMS-*855 via the most cost-effective method available.* Such data includes, but is not limited to:

- Adverse legal history of the provider and all entities and persons listed in sections 5 and 6 of the CMS-855.

- For non-certified suppliers (e.g., physician clinics), all practice locations and phone numbers listed in section 4 of the CMS-855.

- Legal business names and employer identification numbers of all entities listed in sections 5*, 7, 8, and 12* of the CMS-*855.*

Examples of verification techniques include:

- **Phone number of provider's practice location or billing agency -** Calling the number listed on the application directly; checking the Yellow Pages.

- **Provider's practice location -** Checking the Yellow Pages; conducting a site visit.

- **Provider's "doing business as" name –** *Searching State Web sites*

If the discrepancy is found between the information of the application and the data found during the verification process, the contractor shall contact the provider for clarification. .

In addition:

- There may be instances where CMS directs contractors to verify certain data via the Medicare Exclusion Database and/or the GSA Excluded Parties List System. If a potential hit is found on the GSA List and the contractor needs to make a positive identity, it shall contact the agency that took the action for further information; based on this data, the contractor shall determine whether it is the same person. If a positive match still cannot be made, the contractor may approve the application.

- The contractor is not required to use the Fraud Investigation Database (FID) when processing incoming enrollment applications, including changes of information. If the contractor chooses to use the FID on a particular provider, owner, etc., and the person/entity appears on the FID, the contractor should continue to process the application. However, it should refer the matter to the PSC for guidance.

- In some instances, a contractor may need to contact another Medicare contractor for information regarding the provider. The latter contractor shall respond to the former contractor's request within three business days absent extenuating circumstances.

12.2.7 - *Suppliers of Ambulance Services*

(Rev. 296; Issued: 07-10-09; Effective/Implementation Date: 08-10-09)

Per 42 CFR §410.40(d), Medicare covers ambulance services, including fixed wing and rotary wing ambulance services, only if they are furnished to a beneficiary whose medical condition is such that other means of transportation are contraindicated.

A. Types of Ambulance Services

There are several types of ambulance services covered by Medicare. They are defined in 42CFR §414.605 as follows:

*1. **Advanced Life Support, level 1** (ALS1) - Transportation by ground ambulance vehicle, medically necessary supplies and services, and either an ALS assessment by ALS personnel or the provision of at least one ALS intervention.*

***NOTE:** Per 42CFR §414.605, ALS personnel means an individual trained to the level of the emergency medical technician-intermediate (EMT-Intermediate) or paramedic. The EMT-Intermediate is defined as an individual who is qualified, in accordance with State and local laws, as an EMT-Basic and who is also qualified in accordance with State and local laws to perform essential advanced techniques and to administer a limited number of medications.*

*2. **Advanced Life Support, level 2** (ALS2) - Either transportation by ground ambulance vehicle, medically necessary supplies and services, and the administration of at least three medications by intravenous push/bolus or by continuous infusion, excluding crystalloid, hypotonic, isotonic, and hypertonic solutions (Dextrose, Normal Saline, Ringer's Lactate); or transportation, medically necessary supplies and services, and the provision of at least one of the seven ALS procedures specified in 42CFR §414.605.*

*3. **Air Ambulance** (Fixed-Wing and Rotary-Wing) - Air ambulance is furnished when the patient's medical condition is such that transport by ground ambulance, in whole or in part, is not appropriate. Generally, this type of transport may be necessary because: (1) the patient's condition requires rapid transport to a treatment facility and either greater distances or other obstacles (e.g., heavy traffic) preclude such rapid delivery to the nearest appropriate facility; or (2) the patient is inaccessible by ground or water vehicle.*

*4. **Basic Life Support** (BLS) - Transportation by ground ambulance vehicle and medically necessary supplies and services, plus the provision of BLS ambulance services. The ambulance must be staffed by an individual who is qualified in accordance with State and local laws as an emergency medical technician-basic (EMT-Basic).*

*5. **Paramedic ALS Intercept Services** (PI) - Per 42CFR §414.605, EMT-Paramedic services furnished by an entity that does not furnish the ground transport, provided that the services meet the requirements in 42CFR §410.40(c). PI typically involves an arrangement between a BLS ambulance supplier and an ALS ambulance supplier, whereby the latter provides the ALS*

services and the BLS supplier provides the transportation component. Per 42CFR §410.40(c), PI must meet the following requirements:

- *Be furnished in an area that is designated as a rural area;*
- *Be furnished under contract with one or more volunteer ambulance services that meet the following conditions:*
  - *Are certified to furnish ambulance services as required under 42CFR §410.41.*
  - *Furnish services only at the BLS level.*
  - *Be prohibited by State law from billing for any service.*
- *Be furnished by a paramedic ALS intercept supplier that meets the following conditions:*
  - *Is certified to furnish ALS services as required in 42CFR §410.41(b)(2).*
  - *Bills of all the recipients who receive ALS intercept services from the entity, regardless of whether or not those recipients are Medicare beneficiaries.*

*6. **Specialty Care Transport** (SCT) - Inter-facility transportation of a critically injured or ill beneficiary by a ground ambulance vehicle, including medically necessary supplies and services, at a level of service beyond the scope of the EMT-Paramedic. SCT is necessary when a beneficiary's condition requires ongoing care that must be furnished by one or more health professionals in an appropriate specialty area (e.g., nursing, emergency medicine, respiratory care, cardiovascular care, or a paramedic with additional training.)*

B. Ambulance Qualifications

1. Vehicle Design and Equipment

As specified in 42CFR §410.41(a), a vehicle used as an ambulance must meet the following requirements:

- *Be specially designed to respond to medical emergencies or provide acute medical care to transport the sick and injured and comply with all State and local laws governing an emergency transportation vehicle.*
- *Be equipped with emergency warning lights and sirens, as required by State or local laws.*
- *Be equipped with telecommunications equipment as required by State or local law to include, at a minimum, one two-way voice radio or wireless telephone.*

- *Be equipped with a stretcher, linens, emergency medical supplies, oxygen equipment, and other lifesaving emergency medical equipment as required by State or local laws.*

2. Vehicle Personnel

Per 42CFR §410.41(b)(1)(i) & (ii), a BLS vehicle must be staffed by at least two people, one of whom must be: (1) certified as an emergency medical technician by the State or local authority where the services are furnished, and (2) legally authorized to operate all lifesaving and life-sustaining equipment on board the vehicle.

An ALS vehicle, in addition to meeting the BLS vehicle staff requirements described in 42CFR §410.41(b)(2), the previous paragraph, must also have one of the two staff members be certified as a paramedic or an emergency medical technician, by the State or local authority where the services are being furnished, to perform one or more ALS services.

C. Ambulance Claims Jurisdiction

Ambulance claims jurisdiction policies are specified in Pub. 100-04, chapter 1, section 10.1.5.3, and Pub. 100-04, chapter 15, section 20.1.2.

D. Completion of the CMS-855B

Pub. 100-02, chapter 10, section 10.1.3 states that, in determining whether the vehicles and personnel of the ambulance supplier meet all of the above requirements, the contractor may accept the supplier's statement (absent information to the contrary) that its vehicles and personnel meet all of the requirements. The contractor shall note that this provision in no ways obviates the need for the supplier to complete and submit to the contractor the CMS-855B enrollment form (including Attachment 1 thereto and all supporting documents), and does not excuse the contractor from having to verify the data on the CMS-855B enrollment form in accordance with the provisions of Pub. 100-08, chapter 10. In other words, the "statement" referred to in section 10.1.3, does not supplant or replace the CMS-855B provider enrollment process.

E. Miscellaneous Information

*1. **Payment Amounts** - Per 42CFR §414.610(a), Medicare payment for ambulance services is based on the lesser of the actual charge or the applicable fee schedule amount.*

*2. **Non-Emergency Transport** - As stated in 42CFR §410.40(d), non-emergency transportation by ambulance is appropriate if either: (1) the beneficiary is bed-confined, and it is documented that the beneficiary's condition is such that other methods of transportation are contraindicated; or (2) if his or her medical condition, regardless of bed confinement, is such that transportation by ambulance is medically required.*

*3. **Point of Pick-Up** - The point of pick-up (POP), which is reported by the 5-digit ZIP Code, determines the basis of payment under the fee schedule. (See Pub. 100-04, chapter 15, section 20.1.5, for more information on the POP.)*

*4. **Destinations** - As discussed in 42CFR §410.40(e), Medicare covers the following ambulance transportation:*

- *From any point of origin to the nearest hospital, CAH, or SNF that is capable of furnishing the required level and type of care for the beneficiary's illness or injury. The hospital or CAH must have available the type of physician or physician specialist needed to treat the beneficiary's condition.*

- *From a hospital, CAH, or SNF to the beneficiary's home.*

- *From a SNF to the nearest supplier of medically necessary services not available at the SNF where the beneficiary is a resident, including the return trip.*

- *For a beneficiary who is receiving renal dialysis for treatment of ESRD, from the beneficiary's home to the nearest facility that furnishes renal dialysis, including the return trip.*

Per Pub. 100-02, chapter 10, section 10.3.8, ambulance service to a physician's office is covered only if: (1) transport is en route to a Medicare-covered destination, as described in Pub. 100-02, chapter 10, section 10.3; and (2) during the transport, the ambulance stops at a physician's office because of the patient's dire need for professional attention, and immediately thereafter, the ambulance continues to the covered destination.

(See Pub. 100-02, chapter 10, section 10.3.2 for information on "institution-to-institution" ambulance services; as stated therein, there may be instances where the institution to which the patient is initially taken is found to have inadequate or unavailable facilities to provide the required care, and the patient is then transported to a second institution having appropriate facilities. Also see Pub. 100-02, chapter 10, section 10.4.4, for information on hospital-to-hospital air ambulance transport; the air transport of a patient from one hospital to another may be covered if the medical appropriateness criteria are met - that is, transportation by ground ambulance would endanger the beneficiary's health and the transferring hospital does not have adequate facilities to provide the medical services needed by the patient.)

*5. **Local** - Per Pub. 100-02, chapter 10, section 10.3, as a general rule, only local transportation by ambulance is covered, and therefore, only mileage to the nearest appropriate facility equipped to treat the patient is covered.*

*6. **Part A** - For information on the Part A intermediary's processing of claims for ambulance services furnished under arrangements by participating hospitals, SNFs, and HHAs, see Pub. 100-02, chapter 10, section 10.1.4.*

7. ***Air Ambulance and Acute Care Hospitals*** *- As stated in Pub. 100-02, chapter 10, section 10.4.5, air ambulance services are not covered for transport to a facility that is not an acute care hospital, such as a nursing facility, physician's office, or a beneficiary's home.*

For additional information on ambulance services, refer to:

- *Section 1834(l) of the Social Security Act;*
- *42 CFR 410.40, 410.41, and 414.60;.*
- *Pub. 100-02, chapter 10;*
- *Pub. 100-04, chapter 15; and*
- *Section 4.18 of this manual.*