CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-08 Medicare Program Integrity	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 424	**Date: June 13, 2012**
	Change Request 7827

Transmittal 421, dated May 18, 2012, is being rescinded and replaced by Transmittal 424, dated June 13, 2012 to delete section 15.10.2 from "Section II: Changes in the Manual Instructions" of the Transmittal. All other information remains the same.

SUBJECT: General Update to Chapter 15 of the Program Integrity Manual (PIM) - Part VI

I. SUMMARY OF CHANGES: The purpose of this CR is to continue the process of updating chapter 15 of the PIM.

EFFECTIVE DATE: JUNE 19, 2012
IMPLEMENTATION DATE: June 19, 2012

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	15/15.5.19.1/Independent Diagnostic Testing Facility (IDTF) Standards
R	15/15.5.19.2/Multi-State Independent Diagnostic Testing Facilities (IDTFs)
R	15/15.5.19.3/Interpreting Physicians
R	15/15.5.19.4/Technicians
R	15/15.5.19.7/Special Procedures and Supplier Types
R	15/15.9.1/Non-Certified Suppliers and Individual Practitioners
R	15/15.9.3/Approval of Suppliers of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)
R	15/15.10.1/Changes of Information - General Procedures
R	15/15.10.1.1/Changes of Information and Complete Form CMS-855 Applications
R	15/15.10.1.2/Incomplete or Unverifiable Changes of Information
R	15/15.10.3/Voluntary Terminations
R	15/15.14.1/Non-Form CMS-855 Enrollment Activities
R	15/15.14.2/Contractor Communications
R	15/15.14.3/Provider-Based
R	15/15.14.5/Form CMS-855B Applications Submitted by Hospitals
R	15/15.14.6/Participation (Par) Agreements and the Acceptance of Assignment
R	15/15.14.8/Assignment of Part B Provider Transaction Access Numbers (PTANs)
D	15/15.14.9/Assignment of Part B Provider Transaction Access Numbers (PTANs)
D	15/15.14.10/Reciprocal Billing, Locum Tenens and the Provider Enrollment Process
R	15/15.17/Establishing an Effective Date of Medicare Billing Privileges
R	15/15.18/Reserved for Future Use
R	15/15.20/On-site Inspections and Site Verifications
R	15/15.20.1/Site Verifications
R	15/15.20.2/Reserved for Future Use
R	15/15.20.3/National Supplier Clearinghouse (NSC)
R	15/15.21.7.1.1/Model Letters for Claims against Surety Bonds
R	15/15.27.3.1/Zone Program Integrity Contractor (ZPIC) Identified Revocations
R	15/15.27.3.2/CMS Satellite Office or Regional Office Identified Revocations

III. FUNDING:
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.

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: 424	Date: June 13, 2012	Change Request: 7827

Transmittal 421, dated May 18, 2012, is being rescinded and replaced by Transmittal 424, dated June 13, 2012 ,to delete section 15.10.2 from "Section II: Changes in the Manual Instructions" of the Transmittal. All other information remains the same.

SUBJECT: General Update to Chapter 15 of the Program Integrity Manual (PIM) - Part VI

Effective Date: **June 19, 2012**

Implementation Date: June 19, 2012

I. GENERAL INFORMATION

A. Background: This change request (CR) is the sixth in a series of transmittals designed to update chapter 15 of the PIM. The revisions in this CR are either: (1) purely editorial in nature, or (2) incorporate existing policies directly into chapter 15.

B. Policy: The purpose of this CR is to continue the process of updating chapter 15 of the PIM.

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	
7827.1	**NOTE:** The contractor shall observe the editorial and technical revisions to the sections of chapter 15 of the PIM that are included in this CR.	X	X	X	X	X					National Supplier Clearinghouse

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: N/A

X-Ref Requirement Number	Recommendations or other supporting information:
	None

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

V. CONTACTS

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

Post-Implementation Contact(s):
Contact your Contracting Officer 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 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 15 - Medicare Enrollment

Table of Contents
(Rev.424, Issued: 06-13-12)

15.5.19.1 – *Independent Diagnostic Testing Facility (IDTF)* Standards

(Rev. 424, Issued: 06-13-12, Effective: 06-19-12, Implementation: 06-19-12)

A. IDTF Standards

Consistent with 42 CFR §410.33(g), each IDTF must certify on its *Form* CMS-855B enrollment application that it meets the following standards and all other requirements:

1. Operates its business in compliance with all applicable Federal and State licensure and regulatory requirements for the health and safety of patients.

    - The purpose of this standard is to ensure that suppliers are licensed in the business and specialties being provided to Medicare beneficiaries. Licenses are required by State and/or Federal agencies to make certain that guidelines and regulations are being followed *and* to ensure *that* businesses are furnishing quality services to Medicare beneficiaries.

    - The responsibility for determining what licenses are required to operate a supplier's business is the sole responsibility of the supplier. The contractor is not responsible for notifying any supplier of what licenses are required or that any changes have occurred in the licensure requirements. No exemptions to applicable State licensing requirements are permitted, except when granted by the State.

    - The contractor shall not grant billing privileges to any business not appropriately licensed as required by the appropriate State or Federal agency. If a supplier is found providing services for which it is not properly licensed, billing privileges may be revoked and appropriate recoupment actions taken.

2. Provides complete and accurate information on its enrollment application. Changes in ownership, changes of location, changes in general supervision, and *final adverse actions* must be reported to *the contractor within* 30 calendar days of the change. All other changes to the enrollment application must be reported within 90 days.

    NOTE: This 30-day requirement takes precedence over the certification in section 15 of the *Form* CMS-855B whereby the supplier agrees to notify Medicare of any changes to its enrollment data within 90 days of the effective date of the change. By signing the certification statement, the IDTF agrees to abide by all Medicare rules for its supplier type, including the 30-day rule in 42 CFR § 410.33(g)(2).

3. Maintain a physical facility on an appropriate site. *(For purposes* of this standard, a post office box, commercial mailbox, hotel, or motel is *not an* appropriate site. The physical facility, including mobile units, must contain space for equipment appropriate to the services designated on the enrollment application, facilities for hand washing, adequate patient privacy accommodations, and the storage of both business records and current medical records within the office setting of the IDTF, or IDTF home office, not within the actual mobile unit.*)*

- IDTF suppliers that provide services remotely and do not see beneficiaries at their practice location are exempt from providing hand washing and adequate patient privacy accommodations.

- The requirements in 42 CFR §410.33(g)(3) take precedence over the guidelines in sections 15.5.4 and 15.5.4.2 of this chapter pertaining to the supplier's practice location requirements.

- The physical location must have an address, including the suite identifier, which is recognized by the United States Postal Service (USPS).

4. Has all applicable diagnostic testing equipment available at the physical site excluding portable diagnostic testing equipment. The IDTF must—

   (i) Maintain a catalog of portable diagnostic equipment, including diagnostic testing equipment serial numbers, at the physical site;

   (ii) Make portable diagnostic testing equipment available for inspection within 2 business days of a CMS inspection request; and

   (iii) Maintain a current inventory of the diagnostic testing equipment, including serial and registration numbers, and provide this information to the designated fee-for- service contractor upon request, and notify the contractor of any changes in equipment within 90 days.

5. Maintain a primary business phone under the name of the designated business. The IDTF must have its--

   (i) Primary business phone located at the designated site of the business or within the home office of the mobile IDTF units.

   (ii) Telephone or toll free telephone numbers available in a local directory and through directory assistance.

   The requirements in 42 CFR §410.33(g)(5) take precedence over the guidelines in sections 15.5.4 and 15.5.4.2 of this chapter *regarding* the supplier's telephone requirements.

   IDTFs may not use "call forwarding" or an answering service as their primary method of receiving calls from beneficiaries during posted operating hours.

6. Have a comprehensive liability insurance policy of at least $300,000 per location that covers both the place of business and all customers and employees of the IDTF. The policy must be carried by a non-relative-owned company. Failure to maintain required insurance at all times will result in revocation of the IDTF's billing privileges retroactive to the date the insurance lapsed. IDTF suppliers are responsible for providing the contact information for the issuing

insurance agent and the underwriter. In addition, the IDTF must--

(i) Ensure that the insurance policy must remain in force at all times and provide coverage of at least $300,000 per incident; and

(ii) Notify the CMS designated contractor in writing of any policy changes or cancellations.

7. Agree not to directly solicit patients*; this* includes - but is not limited to - a prohibition on telephone, computer, or in-person contacts. The IDTF must accept only those patients referred for diagnostic testing by an attending *physician who: (a)* is furnishing a consultation or treating a beneficiary for a specific medical problem*, and (2)* uses the results in the management of the beneficiary's specific medical problem. Non-physician practitioners may order tests as set forth in §410.32(a)(3).

- By the signature of the authorized official in section 15 of the *Form* CMS-855B, the IDTF agrees to comply with 42 CFR § 410.33(g)(7).

- The supplier is prohibited from directly contacting any individual beneficiary for the purpos*e* of soliciting business for the IDTF. This includes contacting the individual beneficiary by telephone or via door-to-door sales.

- There is no prohibition on television, radio or Internet advertisements, mass mailings, or similar efforts to attract potential clients to an IDTF.

- If the contractor determines that an IDTF is violating this standard, the contractor should notify its Provider Enrollment Operations Group (PEOG) liaison immediately.

8. Answer, document, and maintain documentation of a beneficiary's written clinical complaint at the physical site of the IDTF. (For mobile IDTFs, this documentation would be stored at their home office.) This includes, but is not limited to, the following:

(i) The name, address, telephone number, and health insurance claim number of the beneficiary.

(ii) The date the complaint was received; the name of the person receiving the complaint; and a summary of actions taken to resolve the complaint.

(iii) If an investigation was not conducted, the name of the person making the decision and the reason for the decision.

9. Openly post these standards for review by patients and the public.

10. Disclose to the government any person having ownership, financial, or control interest or any other legal interest in the supplier at the time of enrollment or within 30 days of a change.

11. Have its testing equipment calibrated and maintained per equipment instructions and in compliance with applicable manufacturers' suggested maintenance and calibration standards.

12. Have technical staff on duty with the appropriate credentials to perform tests. The IDTF must be able to produce the applicable Federal or State licenses or certifications of the individuals performing these services.

13. Have proper medical record storage and be able to retrieve medical records upon request from CMS or its fee-for-service contractor within 2 business days.

14. Permit CMS, including its agents, or its designated fee-for-service contractors, to conduct unannounced, on-site inspections to confirm the IDTF's compliance with these standards. The IDTF must---

    (i) Be accessible during regular business hours to CMS and beneficiaries; and

    (ii) Maintain a visible sign posting its normal business hours.

15. Enrolls in Medicare for any diagnostic testing services that it furnishes to a Medicare beneficiary, regardless of whether the service is furnished in a mobile or fixed-base location.

16 Bills for all mobile diagnostic services that are furnished to a Medicare beneficiary, unless the mobile diagnostic service is part of a service provided under arrangement as described in section 1861(w)(1) of the Act. (Section 1861(w)(1) states that the term "arrangements" is limited to arrangements under which receipt of payments by the hospital, critical access hospital, skilled nursing facility, home health agency or hospice program (whether in its own right or as *an* agent), with respect to services for which an individual is entitled to have payment made under this title, discharges the liability of such individual or any other person to pay for the services.)

    If the IDTF claims that it is furnishing services under arrangement as described in section 1861(w)(1), the IDTF must provide documentation of such with its initial or revalidation *Form* CMS-855 application.

The IDTF must meet all of the standards in 42 CFR § 410.33 – as well as all other Federal and State statutory and regulatory requirements – in order to be enrolled in, and to maintain its enrollment in, the Medicare program. Failure to meet any of the standards in 42 CFR §410.33 or any other applicable requirements will result in the denial of the supplier's *Form* CMS-855 application or, if the supplier is already enrolled in Medicare, the revocation of its Medicare billing privileges.

B. Sharing of Space and Equipment

Effective January 1, 2008, with the exception of hospital-based and mobile IDTFs, a fixed-base IDTF does not: (i) share a practice location with another Medicare-enrolled individual or organization; (ii) lease or sublease its operations or its practice location to another Medicare-

enrolled individual or organization; or (iii) share diagnostic testing equipment used in the initial diagnostic test with another Medicare-enrolled individual or organization. (See 42 CFR § 410.33(g)(15).)

If the contractor determines that an IDTF is leasing or subleasing its operations to another organization or individual, the contractor shall revoke the supplier's Medicare billing privileges.

C. One Enrollment per Practice Location

An IDTF must separately enroll each of *its* practice locations (with the exception of locations that are used solely as warehouses or repair facilities). This means that *an* enrolling IDTF can only have one practice location on its *Form* CMS-855B enrollment application; thus, if an IDTF is adding a practice location to its existing enrollment, it must submit a new, complete *Form* CMS-855B application for that location and have that location undergo a separate site visit. Also, each of the IDTF's mobile units must enroll separately. Consequently, if a fixed IDTF site also contains a mobile unit, the mobile unit must enroll separately from the fixed location.

Each separately enrolled practice location of the IDTF must meet *all applicable* IDTF requirements. *The location's f*ailure to comply with any of these *requirements will* result in the revocation of its Medicare billing privileges.

D. Effective Date of Billing Privileges

*T*he filing date of *an IDTF* Medicare enrollment application is the date that *the contractor* receives a *signed application* that it is able to process to approval. (See 42 CFR *§* 410.33(i).) The effective date of billing privileges for a newly enrolled IDTF is the later of the following:

(1) The filing date of the Medicare enrollment application that was subsequently approved by a Medicare fee-for-service contractor; or

(2) The date the IDTF first started furnishing services at its new practice location.

A newly-enrolled IDTF, therefore, may not receive reimbursement for services furnished before the effective date of billing privileges.

The contractor shall note that if it rejects an IDTF *application and* a new application is later submitted, the date of filing is the date the contractor receives the new enrollment application.

E. Leasing and Staffing

For purposes of the provisions in 42 CFR §410.33, a "mobile IDTF" does not include entities that lease or contract with a Medicare enrolled provider or supplier to provide: *(1)* diagnostic testing equipment; *(2)* non-physician personnel described in 42 CFR *§* 410.33(c); or *(3)* diagnostic testing equipment and non-physician personnel described in 42 CFR *§* 410.33(c). This is because the provider/supplier is responsible for providing the appropriate level of physician supervision for the diagnostic testing.

15.5.19.2 – Multi-State *Independent Diagnostic Testing Facilities (IDTFs)*

(Rev. 424, Issued: 06-13-12, Effective: 06-19-12, Implementation: 06-19-12)

As stated in 42 CFR § 410.33(e)(1), an IDTF that operates across State boundaries must:

- Maintain documentation that its supervising physicians and technicians are licensed and certified in each of the States in which it operates; and

- Operate in compliance with all applicable Federal, State, and local licensure and regulatory requirements with regard to the health and safety of patients.

The point of the actual delivery of service means the place of service on the claim form. When the IDTF performs or administers an entire diagnostic test at the beneficiary's location, the beneficiary's location is the place of service. When one or more aspects of the diagnostic testing are performed at the IDTF, the IDTF is the place of service.

15.5.19.3 – Interpreting Physicians

(Rev. 424, Issued: 06-13-12, Effective: 06-19-12, Implementation: 06-19-12)

The applicant shall list all physicians for whose diagnostic test interpretations it will bill. This includes physicians who will provide interpretations subject to the anti-markup payment limitation as detailed in *CMS Publication* 100-04, chapter 1, §30.2.9 - whether the service is provided to the IDTF on a contract basis or is reassigned.

The contractor shall ensure and document that:

- All listed physicians are enrolled in Medicare

- All interpreting physicians who are reassigning their benefits to the IDTF have the right to do so

- All required *Form* CMS-855R forms have been submitted

- The interpreting physicians listed are qualified to interpret the types of tests (codes) listed. (The contractor may need to contact another contractor to obtain this information.) If the applicant does not list any interpreting physicians, the contractor need not request additional information because the applicant may not be billing for the interpretations; that is, the physicians may be billing for the interpretation themselves.

If an interpreting physician has been recently added or changed, the new interpreting physician must have met all of the interpreting physician requirements at the time any tests were performed.

15.5.19.4 – Technicians

(Rev. 424, Issued: 06-13-12, Effective: 06-19-12, Implementation: 06-19-12)

Each non-physician who perform*s I*DTF diagnostic tests must be listed. These persons are often referred to as technicians.

A. Licensure and Certification

All technicians must meet the standards of a State license or State certification at the time of the IDTF's enrollment. Contractors may not grant temporary exemptions from such requirements. Also, the IDTF must attach a copy of each technician's license or certification with its application.

B. Changes of Technicians

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

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

15.5.19.7 – Special Procedures and Supplier Types

(Rev. 424, Issued: 06-13-12, Effective: 06-19-12, Implementation: 06-19-12)

A. Diagnostic Mammography

If an *independent diagnostic testing facility (IDTF)* performs diagnostic mammography services, it must have a Food and Drug Administration (FDA) certification to perform the mammography. However, an entity that only performs diagnostic mammography services should not be enrolled as an IDTF. Rather, it should be separately enrolled as a mammography *screening* center.

B. CLIA Tests

An IDTF may not perform or bill for CLIA tests. However, an entity with one tax identification number (TIN) may own both an IDTF and an independent CLIA laboratory. In such a situation, they should be separately enrolled and advised to bill separately. The contractor shall also advise its claims unit to ensure that the CLIA codes are not being billed under the IDTF provider number.

15.9.1 - Non-Certified Suppliers and Individual Practitioners

(Rev. 424, Issued: 06-13-12, Effective: 06-19-12, Implementation: 06-19-12)

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

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

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

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

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

- *I*nclude language reminding suppliers to update their NPPES record whenever their information changes.

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

15.9.3 - Approval of *Suppliers of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)*

(Rev. 424, Issued: 06-13-12, Effective: 06-19-12, Implementation: 06-19-12)

As stated in 42 CFR §424.57(b), a DMEPOS supplier must, among other things, meet the following conditions to be eligible to receive payment for a Medicare-covered item:

- The supplier has submitted a complet*e Form* CMS-855S, including all supporting documentation, to the *National Supplier Clearinghouse (NSC);* and

- The item was furnished on or after the date the NSC issued to the supplier a DMEPOS supplier number conveying Medicare billing privileges.

The date identified in the previous bullet represents the "date of approval."

15.10.1 – *Changes of Information -* General Procedures

(Rev. 424, Issued: 06-13-12, Effective: 06-19-12, Implementation: 06-19-12)

Unless otherwise specified in this chapter *or another CMS directive*, if an enrolled provider is adding, deleting, or changing information under its existing tax identification number, it must report *the* change using the applicable *Form CMS-855.* Letterhead is not permitted.

The provider shall *(1)* furnish the changed data in the applicable section*(s)* of the form, and *(2)* sign and date the certification statement. In accordance with 42 CFR § 424.516(d) and (e), the timeframes for providers to report changes *to* their *Form* CMS-855 information are as follows:

A. *P*hysicians, 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.): The following changes must be reported within 30 days:

- A change of ownership
- A final adverse action
- A change in practice location

All other informational changes involving the providers listed in this section 15.10.1(A) must be reported within 90 days.

B. All providers and suppliers other tha*n (*1) those listed in section 15.10.1(A); (2) *suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS);* and (3) *independent diagnostic testing facilities (IDTFs):* Any change of ownership, including a change in an authorized or delegated official, must be reported within 30 days. All other informational changes involving the providers listed in this section 15.10.1(B) must be reported within 90 days.

The reporting requirements for IDTFs can be found in 42 CFR *§* 410.33(g)(2) and in section 15.5.19.1*(A)(2)* of this chapter. Reporting requirements for DMEPOS suppliers can be found *in* 42 CFR § 424.57(c)(2))

In addition:

- **Unsolicited Additional Information -** Any new or changed information *that a provider submits* prior to the date the contractor finishes processing a previously submitted change request is considered to be an update to that change request. It is not considered to be a separate change *request.* To illustrate, suppose a provider submits a *Form CMS-855* change *of information*. On the *1*4th day, it submits additional information that it wants to change. *Since* the contractor has not finished processing the first change request, it *should treat* the data in the second change request as being part of the first one.

- **Unavoidable Phone Number or Address Changes** – Unless *CMS* specif*ies* otherwise, any change in the provider's phone number or address *that the provider did not cause* (i.e., area

code change, municipality renames the provider's street) must still be updated via the *Form* CMS-855.

- **Application Signatures -** If the signer has never been reported in section 6 of the *Form* CMS-855, section 6 must be completed in full with information about the individual. *(This policy applies regardless of whether the provider already has a Form CMS-855 on file.)* The contractor shall *ensure that all validation required to be performed with respect to the individual is conducted.*

- **Notifications** – For changes of information that do not require *Regional Office* approval (e.g., *Form* CMS-855I changes*; Form* CMS-855B changes not involving *ambulatory surgical centers or portable x-ray suppliers;* minor *Form* CMS-855A changes), the contractor shall *(1)* furnish written, e-mail, or telephonic confirmation to the provider that the change has been made*, and (2) d*ocument (per section 15.7.3 of this chapter) in the file the date and time the confirmation was made. If, however, the transaction only involves an area code/ZIP Code change, it is not necessary to send confirmation to the provider that the change has been processed.

15.10.1.1 – Changes of Information and Complete Form CMS-855 Applications

(Rev. 424, Issued: 06-13-12, Effective: 06-19-12, Implementation: 06-19-12)

A provider must submit a complete *Form* CMS-855 application if i*t* (1) submits any change request, and (2) does not have an established enrollment record in *the Provider Enrollment, Chain and Ownership System (PECOS).* (For purposes of this requirement, the term "change request" includes *electronic funds transfer (EFT)* changes.) It is immateria*l* (1) whether the *provider or an*other party (e.g*., l*ocal government change*s s*treet name) was responsible for triggering the changed data; or (2) the signer of the change request or EFT form already has a signature on file with the contractor.

If the contractor receives a change request from a provider that is not in PECOS, the contractor *shall develop* for the entire application in accordance with the procedures described *in this* chapter *(i.e.,* the contractor shall treat the transaction as a request for additional information*).* Consistent with existing policies for requesting additional data, the provider has 30 calendar days from the date of the contractor's request to furnish *a complete Form* CMS-85*5.* During this period, the contractor should "hold" (i.e., not process) the change request until the entire application arrives; no *logging and tracking (L & T)* record shall be created in PECOS at this point.

If the provider fails to submit a complete application within the aforementioned 30-day period, the contractor shall *follow* the instructions in section 15.10.1.2*(B)* of this chapter.

If the *provider submits* the application, the contractor shall process it in accordance *with the instructions in this chapter and all other applicable CMS directives.* This includes:

- Processing the complete application *consistent with the timeframes for initial applications in section 15.6.1 of this chapter.*

- *Ensuring that all data elements on the Form CMS-855 have been validated*, as it would with an initial enrollment application. The contractor shall not approve the change request until all data on the *complete Form* CMS-855 has been validated.

- Creating an L & T record and enrollment record in PECOS prior to approving the change request. *T*he transaction should be treated as an initial enrollment in PECOS; internally, the contractor shall treat it as a change of information. As the complete application will presumably incorporate the changed data reported on the *original Form* CMS-855 change request, the contractor shall not take two separate counts (one initial and one change request) for the transaction.

15.10.1.2 - Incomplete or Unverifiable Changes of Information

(Rev. 424, Issued: 06-13-12, Effective: 06-19-12, Implementation: 06-19-12)

The contractor shall follow the instructions in this section 15.10.1.2 if a submitted change request cannot be processed to completion.

A. Provider *Has an Established Enrollment Record in the Provider Enrollment, Chain and Ownership System (PECOS)*

Assume that a provider *with a PECOS enrollment record* submits a *Form* CMS-855 change *request* and (1) fails to timely respond to the contractor's request for additional or clarifying information, or (2) *the changed information cannot be validated. T*he *contractor shall* reject the change request in accordance with section 15.8.2 of this *chapter. Moreover*, if the *changed* information *is* of such materiality that the contractor cannot determine whether the provider still meets *all enrollment* requirements, *the contractor shall refer the matter to its Provider Enrollment Integrity Group (PEOG) liaison for guidance. (*For instance, if the data involves a change in the provider's lone practice location and the contractor cannot verify the validity of the new site, this clearly raises questions as to the provider's continued compliance with Medicare requirements.*)*

B. Provider is Not in PECOS

As stated in section 15.10.1.*1 of* this chapter, if a provider does not have an established enrollment record in PECOS and wants to change any of its existing enrollment or *electronic funds transfer (*EFT*)* information, it must submit a complete *Form CMS-855 b*efore the contractor can effectuate the change. If the *provider fails* to submit the completed form within the applicable 30-day period, the contractor shall request that the provider revalidate its Medicare enrollment information per 42 CFR § 424.515.

15.10.3 – Voluntary Terminations

(Rev. 424, Issued: 06-13-12, Effective: 06-19-12, Implementation: 06-19-12)

Voluntary terminations shall be processed in accordance with the timeframes in section *15.*6.2 et al. of this chapte*r.*

If the termination involves a *certified provider or certified supplier,* the contractor may terminate the entity without making a recommendation to the State *and Regional Office (RO)*. *Within* 3 business days after the contracto*r f*inish*es* processing the termination, however, it shall notify the State and RO *of this via* letter, e-mail, or fax.

Upon receipt of a voluntary termination, the contractor may ask the provider to complete the "Special Payments" portion of section 4 *of the Form CMS-855* so that future payments can be sent thereto. If the provider has no special payments address already on file, the addition should be included in the same transaction as the termination (i.e., one transaction incorporating both items). If the provider wants to change its existing special payments address, the transaction should be treated as a separate change request (i.e., one termination and one change request). The provider is not required to submit a *Form* CMS-588 in conjunction with a termination.

15.14.1 – Non-Form CMS-855 Enrollment Activities

(Rev. 424, Issued: 06-13-12, Effective: 06-19-12, Implementation: 06-19-12)

There are *situations* where the contractor processes non-CMS-855 forms and other documentation relating to provider enrollment. Such activities include:

- EFT agreements (*Form* CMS-588) submitted *alone*
- "Do Not Forward" issue*s*
- Par agreements (*Form* CMS-460*)*
- Returned remittance notice*s*
- Informational letters received from other contractor*s*
- Diabetes self-management notice*s*
- Verification of new billing service*s*
- Paramedic intercept contract*s*
- 1099 issues that need to be resolve*d*

Unless *specified otherwise* in this chapter or *another CMS directive*, the contractor shall not

create a *logging and tracking* record for any non-CMS-855 document or activity other than the processing of par agreements. The contractor should track and record all other activities internally.

15.14.2 – Contractor Communications

(Rev. 424, Issued: 06-13-12, Effective: 06-19-12, Implementation: 06-19-12)

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

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

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

1. *The provider's legal business name, Provider Transaction Access Number, and National Provider Identifier;* and
2. The updated/changed/corrected data (by including a copy of the appropriate section of the *Form* CMS-855).

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

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

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

15.14.3 – Provider-Based

(Rev. 424, Issued: 06-13-12, Effective: 06-19-12, Implementation: 06-19-12)

The contractor shall adhere to the followin*g r*egarding the enrollment of provider-based entities:

- **Certified Provider *or Certified Supplier* Initially Enrolling –** Suppose an HHA *or other certified provider or certified supplier* wishes to enroll and become provider-based to a hospital. The provider*/supplier* must enroll with the contractor as a separate entity. It cannot be listed as a practice location on the hospital's *Form* CMS-855A.

- **Certified Provider *or Certified Supplier* Changing its Provider-Based Status –** If a certified provider *or certified supplier* is changing its status from provider-based to freestanding or vice versa, it need not submit any updates to its Form *CMS-855* enrollment.
- **Group Practice Initially Enrolling –** If a group practice is enrolling in Medicare and will become provider-based to a hospital, the group generally must enroll via the Form CMS-855B if it wants to bill for practitioner services. The group would also need to be listed or added as a practice location on the hospital's *Form CMS-*855A.

- **Group Practice Changing from Provider-Based to Freestanding** – In this situation, the hospital should submit a *Form* CMS-855A change request that deletes the clinic as a practice location. The group may also need to change the type of clinic it is enrolled as; this may require *a new Form CMS-*855B.

- **Group Practice Changing from Freestanding to Provider-Based** – Here, the hospital *must* submit a *Form* CMS-855A change request adding the group as a practice location. The group may also need to change the type of clinic it is enrolled as; this may require a *new Form CMS-855B.*

Unless the *CMS regional office (RO) dictates* otherwise, the contractor shall not delay the processing of *any practice location addition applications* pending receipt of provider-based attestations or RO *approval* of provider-based status.

15.14.5 – Form CMS-855B Applications Submitted by Hospitals

(Rev. 424, Issued: 06-13-12, Effective: 06-19-12, Implementation: 06-19-12)

A. Group Practices

If an entity is enrolling via the Form CMS-855B as a hospital-owned clinic/physician practice, the contractor shall contact the applicant to determine whether the latter will be billing any of the *listed* locations as provider-based. If the applicant will not be billing as provider-based, the contractor shall process the application normally. If, however, the applicant will bill as provider-based, the contractor shall notify the applicant that the hospital must report any changed practice locations to its contractor via the *Form* CMS-855A.

If the supplier is enrolling as a hospital department (under the "Clinic/Group Practice" category on the *Form* CMS-855B) or an existing hospital department is undergoing a change of ownership (CHOW), the contractor shall only issue the necessary billing numbers upon notification that a provider agreement has been issued – or, in the case of a CHOW, the provider agreement has been transferred to the new owner. If, however, the supplier is enrolling as a group practice that is merely owned by a hospital (as opposed to being a hospital department), it is not necessary for the contractor to wait until the provider agreement is issued before conveying billing privileges to the group.

B. Individual Billings

Assume an individual physician works for a hospital and will be billing for services as an individual (i.e., not as part of the hospital service/payment). However, he/she wants to reassign these benefits to the hospital. *T*he hospital *will need* to enroll with the contractor via the *Form* CMS-855B (e.g., as a hospital department, outpatient location).

15.14.6 – Participation (Par) Agreements and the Acceptance of Assignment

(Rev. 424, Issued: 06-13-12, Effective: 06-19-12, Implementation: 06-19-12)

The contractor shall *follow* the instructions in *CMS Publication* 100-04, chapter 1, sections 30 through 30.3.12.3 when handling *issues* related to par agreements and assignment. Queries related to the interpretation of such instructions shall be referred to the responsible CMS component.

15.14.8 – Assignment of Part B Provider Transaction Access Numbers (PTANs)

(Rev. 424, Issued: 06-13-12, Effective: 06-19-12, Implementation: 06-19-12)

The contractor shall only assign the minimum number of PTANs necessary to ensure that proper payments are made. The contractor shall not assig*n a*dditional PTAN(s) to a *supplier merely* because the individual or entity requests one - the only exception being for hospitals that request separate billing numbers for their hospital departments in section 2C of the *Form* CMS-855*B.* However, a hospital requesting an additional PTAN must associate the new PTAN with a *National Provider Identifier* in section 4 of the *Form* CMS-855.

15.17 – Establishing an Effective Date of Medicare Billing Privileges

(Rev. 424, Issued: 06-13-12, Effective: 06-19-12, Implementation: 06-19-12)

(This section only applies to the following individuals and organizations: 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 physician and non-physician practitioner organizations (e.g., group practices) consisting of any of the categories of individuals identified in this paragraph.)

A. Background

In accordance with 42 CFR § 424.520(d), the effective date for the individuals and organizations identified above is the later *of:*

- *The date the physician filed an enrollment application that was subsequently approved, or*

- *The date the physician first began furnishing services at a new practice location.*

Note that the date of filing for Internet-based *Provider Enrollment, Chain and Ownership System (PECOS)* application*s i*s the date that the contractor received an electronic version of the enrollment application and a signed certification statement *submitted via paper or electronically.*

B. Retrospective Billing

Consistent with 42 CFR § 424.521(a), the individuals and organizations identified above *may r*etrospectively bill for services when:

- The supplier has met all program requirements, including State licensure requirements, and

- The services were provided at the enrolled practice location for up to—

1. 30 days prior to their effective date if circumstances precluded enrollment in advance of providing services to Medicare beneficiaries, or

2. 90 days prior to their effective date if a Presidentially-declared disaster under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. §§5121-5206 (Stafford Act) precluded enrollment in advance of providing services to Medicare beneficiaries.

The contracto*r* shall interpret the phase "circumstances precluded enrollment*" to* mean that the physician, non-physician practitioner*,* or physician or non-physician practitioner organization meets all program requirements *(*including State licensure*)* during the 30*-*day *period* before an application was submitted and no final adverse action, as identified in 42 CFR § 424.502, precluded enrollment. If a final adverse action precluded enrollment during th*is* 30*-*day period*,* th*e c*ontractor shall only establish an effective billing date the day after the date *that* the final adverse action was resolved*,* as long as it is not more than 30 days prior to the date *on which* the application was submitted.

C. Legal Distinction between Effective Date of Enrollment and retrospective Billing Date

The effective date of enrollment is "the later of the date of filing or the date (the supplier) first began furnishing services at a new practice location." The retrospective billing date, however, is "up to……30 days prior to (the supplier's) effective date (of enrollment)." To illustrate,

suppose that a non-Medicare enrolled physician begins furnishing services at an office on March 1. She submits a Form CMS-855I initial enrollment application on May 1. The application is approved on June 1. The physician's effective date of enrollment is May 1, which is the later of: (1) the date of filing, and (2) the date she began furnishing services. The retrospective billing date is April 1 (or 30 days prior to the effective date of enrollment), assuming that the requirements of 42 CFR § 424.521(a) are met.

Note, however, that the effective date entered into the Provider Enrollment, Chain and Ownership System (PECOS) and the Multi-Carrier System will be April 1 and that claims submitted for services provided before April 1 will not be paid.

15.18 – *Reserved for Future Use*

(Rev. 424, Issued: 06-13-12, Effective: 06-19-12, Implementation: 06-19-12)

15.20 – On-site Inspections and Site Verifications

(Rev. 424, Issued: 06-13-12, Effective: 06-19-12, Implementation: 06-19-12)

The contractor shall not conduct site verifications to determine if a provider or supplier *(*including physicians and non-physician practitioners*)* is operational unless CMS: *(1)* has already issued formal guidance *to do so*, or *(2)* issues instructions directing *the contractor* to conduct a *pre-enrollment or post-enrollment site verification.*

15.20.1 - Site Verification*s*

(Rev. 424, Issued: 06-13-12, Effective: 06-19-12, Implementation: 06-19-12)

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

A. Background

1. Operational Status

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

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

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

B. Timing

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

C. Documentation

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

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

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

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

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

D. Signed Declaration

The contractor shall also include a signed declaration stating the facts and verifying the completion of the site verification. (A sample declaration is below and may be revised as necessary)

Declaration of <u>(Name of Inspector/Investigator)</u>
In the Case of _____
Provider/Supplier No._____

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

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

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

3. I have been trained as an Investigator and Site Inspector by [Insert Contractor Name], and

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

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

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

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

_____

SIGNATURE OF DECLARANT

E. Determination

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

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

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

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

15.20.2 – *Reserved for Future Use*
(Rev. 424, Issued: 06-13-12, Effective: 06-19-12, Implementation: 06-19-12)

*15.*20.3 - National Supplier Clearinghouse (NSC)
(Rev. 424, Issued: 06-13-12, Effective: 06-19-12, Implementation: 06-19-12)

The (NSC) shall continue to conduct onsite inspections consistent with *its* Statement of Work and any instructions issued by the NSC project officer.

15.21.7.1.1 – Model Letters for Claims against Surety Bonds
(Rev. 424, Issued: 06-13-12, Effective: 06-19-12, Implementation: 06-19-12)

When making a claim against a surety bond n accordance with section 15.21.7.1 of this chapter, the contractor shall use the applicable model letter below:

A. Letter for Overpayments – Supplier is Still Enrolled in Medicare

Date

Surety Name
Surety Address

RE: Supplier Legal Business Name
Supplier DBA Name (if any)
Supplier Address

Dear Surety:

(Supplier legal business name) is currently enrolled in the Medicare program as a supplier of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS). As a condition of its Medicare enrollment, (Supplier) is required – under Federal regulations at 42 C.F.R. § 424.57(d) - to maintain a surety bond in an amount of no less than $50,000. In accordance with this provision, (Supplier) has a $_____ surety bond with your company.

Pursuant to 42 C.F.R. § 424.57(d)(5)(i)(A), the surety must pay CMS – within 30 days of receiving written notice from CMS containing sufficient evidence to establish the surety's liability under the bond – the amount of any unpaid claim for which the DMEPOS supplier is responsible, up to the full penal amount of the bond. An "unpaid claim" is defined in 42 C.F.R. § 424.57(a) as an overpayment made by the Medicare program to the DMEPOS supplier for which the DMEPOS supplier is responsible.

CMS has determined that (Supplier) has incurred an overpayment in the amount of (insert dollar

amount). This determination was made based on the following:

The DME MAC should outline the facts behind the determination, including:
(1) why the original payment was not correct,
(2) how the overpayment was calculated, and
(3) when the overpayment occurred.

Relevant documentation supporting our determination is attached to this letter.

CMS has been unable to recover the full overpayment from (Supplier) using its existing recoupment procedures. (Supplier) has repaid (insert "none" or "only $_____) of the overpayment amount. Consistent with 42 C.F.R. § 424.57(d)(5)(i)(A), therefore, CMS requests that (Surety) make payment to CMS in the amount of (insert applicable amount) no later than 30 days from the date of this letter. Payment shall be made via check or money order and sent to the following address:

Contractor Name
Address
City, State and Postal ZIP Code

The payee shall be (insert DME MAC), which is CMS's Durable Medical Equipment Medicare Administrative Contractor for (Supplier)'s location.

Should you have any questions about this letter, please do not hesitate to contact _____ at _____.

Sincerely,
(Name and title)

cc: National Supplier Clearinghouse
Supplier Name

B. Letter for Overpayments – Supplier is No Longer Enrolled in Medicare

Date

Surety Name
Surety Address

RE: Former Supplier Legal Business Name
Former Supplier DBA Name (if any)
Former Supplier Address

Dear Surety:

(Former Supplier legal business name) was enrolled in the Medicare program as a supplier of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) until (insert effective date of termination/revocation). As a condition of its Medicare enrollment, (Former Supplier) was required – under Federal regulations at 42 C.F.R. § 424.57(d) - to maintain a surety bond in an amount of no less than $50,000. In accordance with this provision, (Former Supplier) obtained a $_____ surety bond with your company.

Pursuant to 42 C.F.R. § 424.57(d)(5)(i)(A), the surety must pay CMS – within 30 days of receiving written notice from CMS containing sufficient evidence to establish the surety's liability under the bond – the amount of any unpaid claim for which the DMEPOS supplier is responsible, up to the full penal amount of the bond. An "unpaid claim" is defined in 42 C.F.R. § 424.57(a) as an overpayment made by the Medicare program to the DMEPOS supplier for which the DMEPOS supplier is responsible.

CMS has determined that (Supplier) incurred an overpayment in the amount of (insert dollar amount). This determination was made based on the following:

The DME MAC should outline the facts behind the determination, including:
(1) why the original payment was not correct,
(2) how the overpayment was calculated, and
(3) when the overpayment occurred.

Relevant documentation supporting our determination is attached to this letter.

CMS has been unable to recover the full overpayment from (Former Supplier) using its existing recoupment procedures. (Former Supplier) has repaid (insert "none" or "only $_____) of the overpayment amount.

(Former Supplier's) surety bond coverage with your company ended on (insert date). However, consistent with 42 C.F.R. § 424.57(d)(5)(iii), the surety is liable for unpaid claims that:

(1) CMS assessed against the supplier based on overpayments that took place during the term of the bond or rider, and

(2) Were assessed by CMS during the 2 years following the date that the supplier failed to submit a bond or required rider or the date that the supplier's Medicare enrollment was terminated, whichever is later.

The overpayment occurred on (insert date), which was within the period of (Former Supplier)'s surety bond coverage with your company. Moreover, CMS has made its overpayment determination within the 2-year period following the date of the termination of (Former

Supplier)'s Medicare enrollment. Consistent with 42 C.F.R. § 424.57(d)(5)(i)(A), therefore, CMS requests that (Surety) make payment to CMS in the amount of (insert applicable amount) no later than 30 days from the date of this letter. Payment shall be made via check or money order and sent to the following address:

Contractor Name
Address
City, State and Postal ZIP Code

The payee shall be (insert DME MAC), which is CMS's Durable Medical Equipment Medicare Administrative Contractor for (Supplier)'s location.

Should you have any questions about this letter, please do not hesitate to contact _____ at _____.

Sincerely,
(Name and title)

cc: National Supplier Clearinghouse
Supplier Name

C. Letter for Civil Monetary Penalties and Assessments – Supplier is Still Enrolled in Medicare

Date

Surety Name
Surety Address

RE: Supplier Legal Business Name
Supplier DBA Name (if any)
Supplier Address

Dear Surety:

(Supplier legal business name) is currently enrolled in the Medicare program as a supplier of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS). As a condition of its Medicare enrollment, (Supplier) is required – under Federal regulations at 42 C.F.R. § 424.57(d) - to maintain a surety bond in an amount of no less than $50,000. In accordance with this provision, (Supplier) has a $_____ surety bond with your company.

Pursuant to 42 C.F.R. § 424.57(d)(5)(i)(A), the surety must pay CMS – within 30 days of receiving written notice from CMS containing sufficient evidence to establish the surety's liability under the bond – the amount of any civil monetary penalty (CMP) and/or assessment for which the DMEPOS supplier is responsible, up to the full penal amount of the bond. (Insert applicable language.……..…..

> *A CMP is defined in § 424.57(a) as a sum that CMS has the authority, as implemented by 42 C.F.R. § 402.1(c) (or the Department of Health and Human Services Office of Inspector General (OIG)) has the authority, under section 1128A of the Act or 42 C.F.R. Part 1003) to impose on a supplier as a penalty.*

OR

> *An assessment is defined as a sum certain that CMS or the Department of Health and Human Services Office of Inspector General (OIG) may assess against a DMEPOS supplier under Titles XI, XVIII or XXI of the Social Security Act.)*

(CMS or OIG, as applicable) imposed a (CMP and/or assessment, as applicable) on (Supplier) on (date) in the amount of ($ _____). The (CMP and/or assessment) was imposed because (insert explanation, using information furnished by CMS or OIG).

Relevant documentation supporting our determination is attached to this letter. (Attach copy of notice of CMP/assessment that was sent to supplier.)

(CMS or OIG, as applicable) has attempted to recover the amount of the (CMP or assessment) from (Supplier) using its existing collection procedures. (Supplier), however, has repaid (insert "none" or "only $_____) of this amount. Consistent with 42 C.F.R. § 424.57(d)(5)(i)(A), therefore, CMS requests that (Surety) make payment to CMS in the amount of (insert applicable amount) no later than 30 days from the date of this letter. Payment shall be made via check or money order and sent to the following address:

Contractor Name
Address
City, State and Postal ZIP Code

The payee shall be the Centers for Medicare and Medicaid Services.

Should you have any questions about this letter, please do not hesitate to contact _____ at _____.

Sincerely,
(Name and title)

cc: National Supplier Clearinghouse
Supplier Name

D. Letter for Civil Monetary Penalties and Assessments – Supplier is No Longer Enrolled in Medicare

Date

Surety Name
Surety Address

RE: Former Supplier Legal Business Name
Former Supplier DBA Name (if any)
Former Supplier Address

Dear Surety:

(Former Supplier legal business name) was enrolled in Medicare as a supplier of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) until (insert effective date of termination/revocation). As a condition of its Medicare enrollment, (Former Supplier) was required – under Federal regulations at 42 C.F.R. § 424.57(d) - to maintain a surety bond in an amount of no less than $50,000. In accordance with this provision, (Former Supplier) obtained a $_____ surety bond with your company.

Pursuant to 42 C.F.R. § 424.57(d)(5)(i)(A), the surety must pay CMS – within 30 days of receiving written notice from CMS containing sufficient evidence to establish the surety's liability under the bond – the amount of any civil monetary penalty (CMP) and/or assessment for which the DMEPOS supplier is responsible, up to the full penal amount of the bond. (Insert applicable language……..

> *A CMP is defined in § 424.57(a) as a sum that CMS has the authority, as implemented by 42 C.F.R. § 402.1(c) (or the Department of Health and Human Services Office of Inspector General (OIG) has the authority, under section 1128A of the Act or 42 C.F.R. Part 1003)) to impose on a supplier as a penalty.*

OR

> *An assessment is defined as a sum certain that CMS or the Department of Health and Human Services Office of Inspector General (OIG) may assess against a DMEPOS supplier under Titles XI, XVIII or XXI of the Social Security Act.)*

(CMS or OIG, as applicable) imposed a (CMP and/or assessment, as applicable) on (Former

Supplier) on (date) in the amount of ($ _____). The (CMP and/or assessment) was imposed because (insert explanation, using information furnished by CMS or OIG).

Relevant documentation supporting our determination is attached to this letter. (Attach copy of notice of CMP/assessment that was sent to former supplier.)

(CMS or OIG, as applicable) has attempted to recover the amount of the (CMP or assessment) from (Former Supplier) using its existing collection procedures. (Former Supplier), however, has repaid (insert "none" or "only $_____) of this amount.

(Former Supplier)'s surety bond coverage with your company ended on (insert date). However, consistent with 42 C.F.R. § 424.57(d)(5)(iii), the surety is liable for CMPs and/or assessments that:

(1) CMS or OIG imposed or asserted against the supplier during the term of the bond or rider, and

(2) Were imposed or assessed by CMS during the 2 years following the date that the supplier failed to submit a bond or required rider or the date that the supplier's Medicare enrollment was terminated, whichever is later.

The (CMP and/or assessment) was based on events that occurred (insert relevant date(s)), which was within the period of (Former Supplier's) surety bond coverage with your company. Moreover, CMS imposed the (CMP and/or assessment) within the 2-year period following the date of the termination of (Former Supplier)'s Medicare enrollment. Consistent with 42 C.F.R. § 424.57(d)(5)(i)(A), therefore, CMS requests that (Surety) make payment to CMS in the amount of (insert applicable amount) no later than 30 days from the date of this letter. Payment shall be made via check or money order and sent to the following address:

Contractor Name
Address
City, State and Postal ZIP Code

The payee shall be the Centers for Medicare & Medicaid Services.

Should you have any questions about this letter, please do not hesitate to contact _____ at _____.

Sincerely,
(Name and title)

cc: National Supplier Clearinghouse

Supplier Name

15.27.3.1 – *Zone Program Integrity Contractor (ZPIC)* Identified Revocations

(Rev. 424, Issued: 06-13-12, Effective: 06-19-12, Implementation: 06-19-12)

Revocation Reason 8 (cited in 42 CFR § 424.535(a)(8)) states as follows:

> *The provider, supplier or DMEPOS supplier submits a claim or claims for services or supplies that could not have been furnished to a specific individual on the date of service. These instances include but are not limited to situations where the beneficiary is deceased, the directing physician or beneficiary is not in the State or country when services were furnished, or when the equipment necessary for testing is not present where the testing is said to have occurred.*

If *a ZPIC* believes that the use of *Revocation Reason 8* is appropriate, the *ZPIC* will develop a case file - including *the* reason(s) for revocation - and submit *the file* and all supporting documentation to *its* respective government task leader (GTL). The *ZPIC* will provide the GTL with 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.

The GTL will review the *ZPIC* case file and:

- Return the case file to *ZPIC* for additional development, or
- Recommend that the *Provider Enrollment Operations Group (PEOG)* consider approval

the *ZPIC* recommendation for revocation.

If *PEOG* concurs with *the* GTL's revocation recommendation, PEOG will*: (1) ensure that the applicable* fee-for-service contractor *is instructed to revoke the provider/supplier's Medicare billing privileges,* and (2) notify the *Division of Medicare Integrity Contractor Operations* of the action taken.

15.27.3.2 - CMS Satellite Office or Regional Office Identified Revocations

(Rev. 424, Issued: 06-13-12, Effective: 06-19-12, Implementation: 06-19-12)

If a CMS satellite office (SO) or regional office (RO) believes that the use of Revocation Reason 8 (see section 15.27.3.1 above) is appropriate, the SO/RO will 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 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 SO/RO's* revocation recommendation, PEOG will*: (1) ensure that the applicable* fee-for-service contractor *is instructed to revoke the provider/supplier's Medicare billing privileges,* and (2) notify the *SO/RO* of the action taken.