Medicare Program Integrity Manual

Chapter 10 - Healthcare Provider/Supplier Enrollment

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(Rev. 41, 05-29-03)

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1 - Introduction - (Rev. 29, 05-31-01)

Provider/supplier enrollment is a critical function that attempts to ensure that only qualified and eligible individuals and entities are enrolled in the Medicare program and receive reimbursement for services furnished to beneficiaries. The following instructions apply to the enrollment of any provider and supplier of Medicare services within the contractor's jurisdiction, such as physicians and non-physician practitioners, hospitals, and other organizations.

Physicians, suppliers, organizations, etc., that wish to be reimbursed for services furnished to Medicare beneficiaries must enroll in Medicare in order to submit claims on behalf of such beneficiaries. If they do not enroll, they cannot receive payments for Medicare covered services.

1.1 - Definitions Related to Enrollment - (Rev. 41, 05-23-03)

Applicant--the individual practitioner/provider/supplier who is applying for the Medicare number.

Authorized Official--an appointed official to whom the provider/supplier has granted the legal authority to enroll it in the Medicare program, to make changes and/or updates to its status in the Medicare program (e.g., new practice locations, change of address, etc.) and to commit the provider/supplier to fully abide by the laws, regulations, and program instructions of Medicare. The authorized official must be the provider's/supplier's general Partner, chairman of the board, president, chief financial officer, or chief executive officer, or must hold a position of similar status and authority within the provider/supplier. An authorized official can also be anyone who is a direct owner of 5 percent or more of the provider/supplier. An entity can have only one designated authorized official at one time.

Bankruptcy--when a provider/supplier files for protection in a Federal bankruptcy court, it may choose, with the permission of the court, to cease operations (Chapter 7) or reorganize (Chapter 11). When a provider/supplier files under Chapter 7, it will liquidate its assets and cease operations and must notify the contractor of this fact. When the assets are sold to a different entity, that entity must enroll with the contractor if it wishes to bill the Medicare program.

Billing Agency--a company that the applicant contracts with to prepare or to edit the content of the claim.

Delegated Official--an individual who has been delegated the legal authority by the authorized official of that provider/supplier to make changes and/or updates to the organization's status in the Medicare program (e.g., new practice locations, change of address, etc.) and to commit the provider/supplier to fully abide by the laws, regulations, and program instructions of Medicare.

Divestiture--the act of a provider/supplier selling off Part or all of its assets, whether voluntarily or by court order. Whether or not a divestiture constitutes a CHOW for a provider depends on the structure of the transaction.

Deactivate--The provider/supplier will be unable to use its billing number for claims processing. Upon taking this action, notify the applicant the contractor has done so and the reason.

Joint Venture--a business undertaking involving a one-time grouping of two or more entities. Although a joint venture is treated like a Partnership for Federal income tax purposes, it is different from the latter in that it does not involve a continuing relationship among the Parties. Joint Ventures are, in a sense, short-term Partnerships.

Legal Business Name--the name that is reported to the Internal Revenue Service (IRS).

Medicare Identification Number--a generic term for any number that uniquely identifies the enrolling individual or organization. Some examples of Medicare identification numbers include: Unique Physician Identification Numbers (UPINs), Provider Identification Numbers (PINs), Online Survey Certification and Reporting (OSCAR) numbers, and National Supplier Clearinghouse (NSC) numbers.

Mobile Facility/Portable Unit--these terms apply when a service that requires medical equipment is provided in a vehicle, OR the equipment for the service is transported to multiple locations within a geographic area. The most common types of mobile facilities/portable units are mobile independent diagnostic testing facilities, Portable X-ray units, portable mammography units, and mobile clinics. Physical therapists and other medical practitioners (e.g., physicians, nurse practitioners, physician assistants) who perform services at multiple locations (i.e., house calls, assisted living facilities) are not considered to be mobile facilities/portable units.

Supplier--A physician or other practitioner, or an entity other than a provider, that furnishes health care services under Medicare.

Tax Identification Number--the number that the individual or organization uses to report tax information to the IRS, such as a Social Security Number (SSN) or Employer Identification Number (EIN).

1.2 - Applicant versus Provider/Supplier – (Rev. 29, 07-26-02)

The provider is the entity that is furnishing the service, (e.g., the hospital, home health agency, etc.) The applicant is the business entity that the provider is set up as. For instance, suppose the provider is a hospital that is organized as a corporation. (That is, the hospital and the corporation are one in the same, operating under the same tax identification number (TIN)). In this case, the hospital is the provider, and the corporation is the applicant.

1.3 – Benefit Integrity (BI)/Payment Safeguard Contractor versus Provider Enrollment – (Rev. 41, 05-23-03)

If functions outlined in the PIM require Benefit Integrity/PSC intervention, however, the Provider enrollment unit is able to make the query, they can do so. If you do not have a BI unit, follow the appropriate protocol as outlined within your contractor guidelines.

2 - General Instructions - (Rev. 41, 05-23-03)

2.1 – Forms – (Rev. 41, 05-23-03)

The forms that support the enrollment effort are the:

- Application for Individual Health Care Practitioners (Form CMS-855I)--a physician or non-physician practitioner who renders medical services to Medicare beneficiaries must complete this application. This form is processed through the Medicare carrier.

- Individual Reassignment of Benefits (Form CMS-855R)--an individual who renders services and seeks to reassign his/her benefits to an eligible entity must complete the Form CMS-855R for each entity eligible to receive reassigned benefits. The person must be enrolled in the Medicare program as an individual prior to reassigning his/her benefits. The Form CMS-855R may be submitted concurrently with the Form CMS-855.

- Application for Health Care Suppliers that will Bill Medicare Carriers (Form CMS-855B)--this application is to be completed by a supplier (e.g., Ambulance Company) that will bill Medicare carriers for medical services furnished to Medicare beneficiaries. It is not used to enroll individuals.

- Application for Health Care Providers that will Bill Medicare Fiscal Intermediaries (Form CMS-855A)--this application is to be completed by a provider (e.g., hospital) that will furnish medical services to Medicare beneficiaries and bill fiscal intermediaries.

- DMEPOS Supplier Application (Form CMS-855S)--a supplier that wishes to enroll in the Medicare program and provide Medicare beneficiaries with durable medical equipment, prosthetics, orthotics, or supplies (DMEPOS) must complete the Form CMS-855S. The National Supplier Clearinghouse (NSC) is responsible for processing the application.

The Medicare Federal Health Care Provider/Supplier Enrollment Applications (Form CMS-855I, Form CMS-855R, Form CMS-855B, Form CMS-855A and Form CMS-855S) are forms issued by CMS and approved by the Office of Management and Budget (OMB). These forms may not be altered in any way. The forms are used to collect general information about providers/suppliers/DMEPOS supplier to ensure that the applicant is qualified and eligible to enroll in the Medicare program. In some circumstances, this information is necessary to determine the proper amount of Medicare payment. This information may also be used in any litigation that may arise (e.g., the collection of overpayments).

When contractors receive a request for the enrollment application, provide the applicant with the contractor's address so he/she knows where to return the completed application. Also, provide the applicant with the following:

- Notification of any special documentation required for the applicant's provider/supplier type;
- Medicare Authorization Agreement for Electronic Funds Transfers (*Form CMS*-588); and
- Electronic Data Interchange (EDI) agreement.
- The Medicare Participating Physician or Supplier Agreement (Form *CMS*-460), with a letter explaining the purpose of the agreement and how it differs from the actual enrollment process.

A separate application must be submitted for each provider/supplier type. For example, a physician who wishes to bill *as a* DMEPOS supplier must submit two separate applications - the Form CMS-855I (to enroll as a physician) and the Form CMS-855S (to enroll as a DMEPOS supplier).

The use of a computer generated Form CMS-855A/B is acceptable. Currently, the CMS Web site has all the enrollment forms on line. Contractors must link to CMS's Web site to have access to the application available from the contractor's Web site. Any form that is not exactly the same as the application must be rejected unless the discrepancies are only in spacing for fields to be filled in (e.g., all the wording is the same). We expect the contractor to occasionally review the certification statement to ensure that it is worded exactly as the same *as* the printed version. If it is not, request additional information. See §14.1.

The applicant can use copies of previously submitted portions of the application with attachment sheets to submit a new version of the Form CMS-855. This is *practicable* when the applicant is submitting numerous applications for branches or chains. However, a separate stand-alone Form CMS-855 is required for each separately certified entity (each OSCAR number). The contractor who receives multiple Form CMS-855s for related entities can perform concurrent reviews to save time and money. However, any information that is more than 3 years old must be reverified. In general, the format of any information submitted by the applicant must be that shown on Form CMS-855.

2.2 - Contractor Duties – (Rev. 41, 05-23-03)

As Part of the enrollment process, contractors must:

- Assign staff to the Provider/Supplier Enrollment (PSE) function corresponding with the enrollment workload in order to meet processing time requirements while still effectively screening applicants. Employees must receive formal training on enrollment requirements, procedures, and techniques. Staff must receive yearly refresher training. If there is not formal classroom training in this area, the following shall be done:

    - Provide each employee with a general review of the Medicare program.

    - Provide a minimum of one month side-by-side training with an experienced Provider Enrollment Analyst.

    - The supervisor/lead analyst shall test the employee to ensure that the analyst has been trained in the day-to-day operations of the unit.

    - The supervisor/lead analyst shall provide biweekly quality checks for the 1st 6 months of employment (in the provider enrollment section).

    - The employee must be competent in the review of applications. The contractor shall document why the employee is considered competent. An example would be when the employee is an auditor who has reviewed all of CMS's relevant manuals and procedures and attends the provider enrollment conference. Attendance at the yearly provider enrollment conference would meet the annual refresher training.

- Review each Form CMS-855 in its entirety before taking any action, including requesting additional information. *Enter the data within the application in the Provider Enrollment and Chain Ownership System (PECOS) under logging and tracking. For those applications that are denied, and contractors were able to detect this in the prescreening phase, it is not necessary to continue to develop the application. For further information regarding denial, refer to §14.3.* For those contractors who do not have access to PECOS, continue to capture this information in the contractor's current enrollment system. All original applications (regardless if denied, approved, or returned for additional information) must be retained on file according to the records retention requirements listed in §21.

- Review the application to determine that it is complete and that all information and supporting documentation required for the applicant's provider/supplier type has been submitted on and with the appropriate Form CMS-855.

- Verify and validate the information collected on the Form CMS-855 using Qualifier.net.

- Share information with other carriers and intermediaries concerning any experiences during the enrollment process to help identify potential program integrity issues affecting other jurisdictions.

- Coordinate with state survey/certification agencies and CMS Regional Offices *(ROs)*, as needed.

- Capture and maintain the application's certification statement (in house) to verify and validate any request for changes. The change request signature must be checked against the original signature to determine the validity of any changes. This check can be made against a digital/photo image kept in-house.

- Keep all applications, related information, and documentation in a secure environment. For further clarification, see § 24. Note that these instructions are in addition to, and not in lieu of, any other instructions issued by CMS regarding security.

- Confirm that the applicant, all names and entities listed on the application, and any names or entities ascertained through the use of an independent verification source, are not presently excluded from the Medicare program by the HHS Office of Inspector General (OIG). This query shall be done through the Medicare Exclusion Database (MED). The MED *replaced* the OIG file, Pub.69. (Contractors can access MED through Qualifier.net.)

- Confirm that the applicant, all names and entities listed on the application, and any names or entities ascertained through the use of an independent verification source do not appear on the "List of Parties Excluded from Federal Procurement and Nonprocurement Programs (List of Parties)." This must be accomplished by using Qualifier.net.

- Confirm that enrolled providers and suppliers are reviewed against periodically/monthly updated versions of the OIG/MED. This is to ensure that billing privileges are not retained by providers/suppliers that become excluded after enrollment.

- *Check the applicant's name and all names and entities listed on the application that show they have a Medicare identification number (or had one) against the Fraud Investigation Database (FID). If during the review contractors find that a name/entity has (or had) a Medicare identification number and did not disclose it has or had a Medicare identification number, contractors must check the name against the FID.*

- Review all names and entities listed on the application (or obtained through the use *of the executive summary*) against the Healthcare Integrity and Protection Data Bank (HIPDB).

- *Process applications within the time frames described in §15.*

- Coordinate with the Benefit Integrity/PSC to determine patterns and relationships among *providers and* suppliers.

- Maintain a Web site and have the ability to link to the CMS Web site to access the application forms that providers/suppliers may, at a minimum, complete on-line, print, and mail (via hard copy).

- The NSC shall maintain a national master file of all DME suppliers and share that information with the DMERCs.

- Enter/update data on individual practitioners and other suppliers as applicable in the UPIN Registry.

- Review and investigate billing agency agreements (if necessary) and provider/supplier reassignments of Medicare payments to ensure full compliance with operational guidelines.

- Capture when a provider/supplier exceeds five different individual reassignments and contact the provider/supplier to verify that all reassignments are still current and legitimate.

- Enroll Managed Care Organizations (MCOs) and assign billing numbers to allow for fee-for-service payments. This includes all MCOs that have a contract with CMS, to include Medicare + Choice. See §9 for further information.

2.3 - Forms Disposition – (Rev. 41, 05-23-03)

Whenever contractors receive an enrollment package from an entity that wants to enroll a group *and* individual practitioners and/or non-physician practitioners, and those practitioners *who* want to reassign benefits to the group, but the appropriate forms have not been completed, review the package in its entirety to determine the appropriate action. Consider the following scenarios:

Only the 855Rs are submitted

If a brand new group with new practitioners is attempting to enroll but submits only the Form CMS-855Rs for its group members (neither the *initial* Form CMS-855B nor the *initial* Form CMS-855Is were submitted), contractors must return the Forms CMS-855Rs within 15 days of receipt. *Contractors should identify this situation during the prescreening phase. Contact* the applicant by telephone (if the contractor cannot reach the applicant by telephone, a written follow-up is appropriate) *and educate* the group of the appropriate forms *(855Is and 855B) that are needed to process the enrollment package. Inform the group to resubmit the 855Rs with the completed package. Contractors should also forward the group the appropriate forms to complete or note the Web site where the enrollment forms can be found. Once the entire package is received, contractors can begin processing the applications. It is not necessary to begin tracking the 855Rs for timeliness concerns until the appropriate forms are submitted. However, you can track within your system that the forms were returned.*

Only the 855B is submitted

If a brand new group wants to enroll but submits only the Form CMS-855B without attaching the Form CMS-855Is and Forms CMS-855Rs for its group members (i.e., the

855B arrives alone, without the 855Is nor the 855Rs), *return the Form CMS-855B. Contractors should identify this situation during the prescreening phase. Contact the applicant by telephone (if the contractor cannot reach the applicant by telephone, a written follow-up is appropriate) and educate the group of the appropriate forms (855Is and 855Rs) that are needed to process the enrollment. Inform the group to resubmit the 855B with the package. Contractors must also forward the group the appropriate forms to complete or note the Web site where the enrollment forms can be found. Once the entire package is received, the contractor can begin processing the applications.*

855Is and 855B are submitted

If a brand new group wants to enroll and submits *both* the Form CMS-855B and Form CMS-855Is, but fails to submit Form CMS-855Rs for its group members*, review the 855Is that were submitted for possible development. If Form CMS-855Is indicate that the individual is working both in his/her own private practice as well as reassigning benefits to a group, contractors can begin processing the individual application with the practice location for the individual's practice. If, however, the individual is rendering all of his/her services to the group, return the 855Is with Form CMS-855B. Contractors should develop for this situation during the prescreening phase. Contact the applicant by telephone (if contractors cannot reach the applicant by telephone, a written follow-up is appropriate) and educate the group of the appropriate form (855Rs) that is required to process the enrollment package. Inform the group to resubmit the CMS-855B and CMS-855Is with the completed package. Contractors must also forward the group the appropriate forms to complete or note the Web site where the enrollment forms can be found. Once the entire package is received, the contractor can begin processing the applications. Do not track the 855B (or CMS-855Is, if applicable) until the appropriate forms are resubmitted. You can however, track that the forms were returned.* Once contractors receive the 855R forms, contractors can begin enrolling the group *and individuals (as applicable)*.

Applicant Enrolled Prior to Enrollment Form

In situations where the individual/group was enrolled prior to Form CMS-855, certain information is needed to ensure we are making appropriate payment to that individual/group. If an individual/group wants to make a change to a pay-to-address, we require the individual/group to complete the CMS-855 form. Since that individual's/group's information was submitted prior to a Form CMS-855/HCFA-855 enrollment, contractors have no way of knowing who is entitled to make such changes to the pay-to-address. Therefore, request that the individual/group complete the CMS-855 anytime the supplier wants to make a change to a pay-to-address. Contractors do not need to obtain attachments from those individuals/groups who are currently enrolled. If the individual/group already has its EDI/EFT/Participation agreement established, contractors do not need to request these attachments unless the contractor has a reason to do so.

The request for Form CMS-855 is a one-time request. If the individual/group fails to provide the contractor this information, do not allow the group to make a change to the pay-to-address until the information is updated. Once the information is provided process

the change immediately. Contractors have 45 days to process the application. Contractors should develop for these situations in the prescreening phase.

In situations where an individual is joining a group, and neither the group nor the individual were enrolled prior to Form CMS-855, we require the contractor to obtain/develop a complete Form CMS-855B. However, until such time as carriers begin to use PECOS, we are temporarily suspending the requirement. Once PECOS is operational, the requirement to collect a Form CMS-855 will resume. In situations where the group is asking to add an individual to an existing group, and the contractor has to obtain the 855 form, do not hold any payment from the group. Once the group's application is received, the contractor can add the new reassignment. If the entity fails to provide you the information, the contractor cannot add the reassignment until it is received. Contractors do not need to obtain attachments from those individuals/groups who are currently enrolled. If the individual/group already has its EDI/EFT/Participation agreement established, contractors do not need to request these attachments unless the contractor has a reason to do so.

Failure to Sign and/or Date the Application

In those situations where the applicant has failed to sign and/or date its enrollment application, the following instructions apply:

FORM CMS-855I

- *If the physician/practitioner applying for the billing number failed to sign the application (i.e., the signature line is left blank; someone else signed the form on the physician/practitioner's behalf, such as an office manager), return the application immediately. Do not begin processing.*

- *If the physician/practitioner signed the form but failed to date his/her signature, begin the verification process as normal. Once you finish processing the application, request a dated copy of the certification statement. You can accept the dated certification statement by fax. However, you must compare signatures to the original 855. You cannot accept a signature by fax. A signature must always be an original. If you are requesting additional information beyond the dated certification statement, the applicant should at that time also provide the contractor with any additional information needed as a result of the review of the application. The time frame starts when contractors received the application initially.*

Form CMS-855A/CMS-855B

- *If the authorized official statement signature line is blank, return the application immediately. Do not begin processing.*

- *If an individual who signed the application does not appear to have the authority to act as an authorized official, follow the instructions in §3.15 (for carriers) and §10.15 (for intermediaries).*

- *If the correct person (i.e., the individual qualifies, in the contractor's view, as an authorized official) signed the form but failed to date his/her signature, begin the verification process as normal. Once this is completed, send a photocopy of the application along with a blank certification statement page to the applicant. The authorized official must sign and date the certification statement. The applicant should at that time also provide any additional information needed as a result of the review of the application. The time frame starts when the contractor receives the application initially.*

Situations not described above should follow the same logic. Educate the applicant throughout the enrollment process.

3 - Application Sectional Instructions for Carriers – (Rev. 29, 07-26-02)

These instructions are written to provide guidance to Medicare carriers on how to process enrollment applications. This section is organized in three Parts. They are: General, Individual and Supplier.

Since the carrier is responsible for processing the Form CMS-855I and the Form CMS-855B, the manual will provide instructions on how to enroll an individual and a supplier. The term supplier includes groups and organizations. The instructions list two subheadings: Individual and Supplier. When processing an individual application Form CMS-855I, the carrier will follow all Individual instructions. When processing a supplier application Form CMS-855B, the carrier will follow the Supplier instructions. If the section is not labeled, the instruction is applicable for both the individual and supplier application.

Anytime contractors need to request information from an applicant, provide the applicant with a name and contact person so the applicant can reach the contractor directly.

3.1 - Processing the Application – (Rev. 41, 05-23-03)

Section 1: General Application Information - Form CMS-855I and/or Form CMS-855B

The applicant must state the reason for submitting the application.

A. Reason for Submittal of this Application

1. Check one:

If the applicant fails to check any of the boxes to indicate why the application is being submitted, review the application to determine the reason for submittal. If contractors can make that determination on the contractor's own, continue to process the application. If contractors cannot make a determination, contact the applicant by telephone for additional information, see §14.1.

Initial Enrollment--Any individual/supplier who: (1) is enrolling in the Medicare program for the first time with the carrier under this tax identification number or (2) has already enrolled with another carrier but needs to enroll in the contractor's jurisdiction, would check this box. Also, if an applicant is seeking to reestablish him/herself in the Medicare program after reinstatement

from an exclusion, the applicant would enroll as if it were an initial enrollment. Although the application would be checked as an initial enrollment, the individual/supplier would retain his/her original billing number so that CMS can continue to monitor if he/she meets the conditions of enrollment. New hospitals *that* are requesting enrollment with the carrier to bill practitioner services for hospital departments, outpatient locations and/or hospital clinics must check this box.

Reactivation--An applicant would check this box to reestablish billing privileges after deactivation for non-billing.

Contractors must deactivate a billing number any time an individual/supplier has not billed the program for 4 consecutive quarters. When contractors deactivate a number, inform the individual/supplier that his/her billing number was deactivated and that, prior to submitting claims, he/she must reactivate billing privileges.

NOTE: The fact that a number has been deactivated does not change the status of an individual/supplier to have Medicare privileges. Therefore, if contractors receive an inquiry from the Medicaid office asking whether the supplier has a Medicare number, state, "YES." Regardless of whether the number is deactivated, the individual/supplier is still considered *as* having Medicare privileges. Do not confuse the status of a deactivated individual/supplier with one who has been revoked or has been denied Medicare privileges.

Prior to reactivating a billing number, the individual/supplier must be able to submit a valid claim. *(The claim need not have ultimately been paid.)* He/she must also meet all current requirements for that individual/supplier type, regardless of when he/she was previously enrolled in the program (unless stated otherwise in CMS regulations). When the individual/supplier reactivates his/her billing privileges, he/she is required to verify that the information on the contractor's file is current. This can be done by printing out what is currently on file or photocopying a previous application and have the applicant sign a certification statement to state that the information is still true and accurate. If the applicant has never completed the Form CMS-855I or Form CMS-855B, request that he/she do so now.

If contractors have various forms on file, i.e., a Form CMS-855 and changes, request that he/she submit an enrollment form and provide contractors with the pay-to-address and practice location on Form CMS-855 (with any changes) *along with a signed* certification statement. If the applicant provides contractors with any changed data, contractors must verify the new information. If the data is the same as previously recorded, and the contractor is not revalidating the information, do not verify/validate the information as it has already been verified previously.

Contractors must be able to identify when an individual/supplier has not billed the program within 4 consecutive quarters. Contractors must, on a quarterly basis, identify all individuals/suppliers who have not billed the contractor in the stated time frame.

Once contractors identify such an individual/supplier, notify the individual/supplier that its number has been deactivated for security purposes and, that prior to submitting a claim, they will be required to furnish contractors with Form CMS-855 information.

The following stock language can be used:

> "Dear Provider/Supplier:
>
> We have observed that in the past 12 months no claims have been submitted under your Medicare billing number, (inserting billing number). Due to lack of activity, CMS will deactivate your billing number as of (add date of deactivation), rendering your number as inactive.
>
> You may wish to resume your active status in the program at a later date. Upon doing so, you must complete an enrollment application if you have never done so, or you will be asked to update your current application when you resume services to Medicare beneficiaries and bill for those services rendered on their behalf.
>
> If you have any questions regarding this letter, please contact (insert name and phone number of contact)."

Change of Information--Any time a currently enrolled provider or supplier is adding, deleting, or changing information under the same tax identification number, it must report this change using the Form CMS-855. The applicant should check the appropriate changed section on the application in Section 1A1 and identify him/herself. Only the reported changes need to be completed on the application. For example, if an applicant is changing his/her correspondence address and a contact person is not listed, assume that the contact person is the same person as identified in the initial enrollment. The applicant is not required to provide a new application. Always require that the certification statement in §15 be signed and dated.

All change of information certification statements must be signed and verified against the signature of the original Form CMS-855I or Form CMS-855B. Contractors may check the original signature on file against a photo/digital image. If contractors determine that the certification statement was not signed by the supplier or the certification statement *signature* does not match, alert Benefit Integrity/PSC (BI) for further action. If contractors must confirm who is the appropriate Party signing the application, the contractor can request it be notarized. This should only happen if contractors encounter a problem.

If the applicant is making a change to his/her practice location, and that location is in another state within the contractor's jurisdiction, request the state license with that change. Contractors must validate any change to a Pay-to-Address. See §4C "Pay-to-Address" for further instructions.

Voluntary Deactivation of Billing Number - Effective Date (MM/DD/YYYY)--When a supplier will no longer submit claims to the Medicare program, the individual/supplier closes its business or leaves a group practice, etc., it should voluntarily deactivate its number. This is to prevent any fraudulent abuse of the number. The applicant must provide the contractor with the date it stopped practicing under this number. This deactivation is different from an applicant who has not billed the program for 4 consecutive quarters. Any individual/supplier who is placed on a

corrective action plan cannot deactivate its billing number to circumvent its agreement with Medicare.

Hospital Only - Change of Ownership--If a hospital is undergoing a formal CHOW in accordance with 42 C.F.R. 489.18 and the hospital desires to continue billing for practitioner services, then they should complete this box. The hospital is required to submit a separate Form CMS-855A to the intermediary. If as a result of a CHOW, the hospital desires to deactivate its billing number with the carrier, it should check voluntary deactivation of billing number.

If a Portable X-ray Facility or Ambulatory Surgical Center is undergoing a change of ownership in accordance with the general principles outlined in 42 CFR 489.18, it should check this box. See §8 of these instructions (enrolling certified suppliers who enroll with the carrier) for more information.

2. Social Security Number (SSN)/Tax Identification Number (TIN)

If contractors discover that an applicant has used a different SSN/TIN in the past, or is identified by a different number, deny the application; see §14.3, Denial 6. An application cannot be approved until all SSNs/TINs have been appropriately supplied. *Section* 1124(a)(1) and 1124A(a)(3) of the Social Security Act require both SSNs and EINs on the Form CMS-855. The Social Security Administration (SSA) and the Secretary of the Treasury, through the IRS, verify that the SSNs and EINs collected match the disclosing individual/entity on the application. An automatic verification will occur when PECOS becomes operational. Contractors must also *use* Qualifier.net to identify any SSNs that may have been used previously. If a number is found in Qualifier.net that differs from the number on the application *you must reconcile this issue. If contractors determine that this appears to be fraudulent, refer this to Benefit Integrity/PSC. For example, if the executive summary shows a different name and SSN than that associated with the applicant, this would be cause for referral.* If an applicant does not provide a SSN/TIN as requested, request additional information and inform the applicant that steps can be taken to terminate the Medicare relationship. If all means to collect this information fail, deny the application. See §14.3-Denial 6. For those individuals who use a SSN as a tax identification number, validate the number as stated below.

Tax Identification Number (TIN)-31 U.S.C. 7701 requires that all individuals and entities doing business with the United States provide their TIN. The TIN can be either the SSN or an EIN, and appears with the legal business name used when reporting taxes to the IRS. Validate the TIN against IRS paperwork, such as a CP575 (a computer-generated form), a form 990, a quarterly tax payment coupon, or other IRS correspondence that contains the applicant's name and the TIN. *Note that the documentation must come from the IRS. An application for a TIN is not acceptable.* If an applicant cannot obtain the required IRS document, then an explanation must be given in a separate attachment and evidence provided that links the business name with the TIN listed. An applicant may request a verification letter (IRS 147c) from the IRS of their TIN and legal business name. For example, if a supplier changes its name and the IRS does not send an updated document, the supplier may then submit the old IRS document with the old name, as well as a copy of documentation filed with the state or IRS concerning the name change with an explanation of the situation. If the applicant fails to provide the contractor with this information, or it does not match, deny the application; see §14.3, Denial 6.

If an individual is using his/her own SSN to report earnings, the only validation that would need to be made is to confirm that the SSN belongs to that person. This should be done through qualifier.net. Therefore, no other Tax ID documentation is necessary when individuals use their own SSN for tax purposes. Carriers should not require additional tax documentation or social security cards in this situation. Additional documentation should only be submitted when an individual or entity doing business is using a number other than its SSN.

3. Is the supplier currently enrolled in the Medicare program?

This section will indicate if the applicant is currently enrolled in another carrier's jurisdiction. If yes, the applicant *must* list the name of the carrier and its assigned billing number. The applicant does not need to list prior numbers that are no longer active. Verify that the Medicare identification number is correct if reported.

If contractors find a number that was not reported, and it is active, request that the applicant provide additional information, see §14.1.

In some instances, contractors may need to contact other Medicare contractors for information regarding the supplier's status with that contractor; i.e., overpayments, pending adverse action or existing adverse action against the supplier, owner, or managing employee. Any carrier who receives this request must respond to the carrier's inquiry within five days absent extenuating circumstances. If the other carrier indicates suspicion or existence of fraud or other problems, alert Benefit Integrity/PSC and pend the application until directed otherwise. Contact the OIG if necessary.

3.2. Identification – (Rev. 41, 05-23-03)

Section 2: Practitioner Identification - Form CMS-855I

A. Personal Information

Check each section to see whether the applicant is changing previous information. If yes, verify that the effective date is listed. If the applicant fails to provide contractors with an effective date, request additional information, see §14.1.

1-2. Contractors must verify that the applicant has completed the requested information and that the name on the license matches the name in this section. If for some reason the name does not match, and the contractor cannot verify that this is the same person, deny the application; see §14.3, denial.

2. If an applicant fails to list his/her middle initial, yet it is on the license, it is not necessary to request additional information. However, if a surname differs, and the applicant hasn't provided the contractor with proof of a name change (such as a marriage license, etc), the contractor shall request additional information; see §14.1. If contractors determine that the applicant does not have a license or is not authorized by the Federal/State/local government, deny the application; see §14.3, denial 2.

3. The applicant's date of birth, State, and country is used to uniquely identify the individual. If contractors discover that a date of birth does not match, by using Qualifier.net, contact the applicant, see §14.1. If the contractor finds any information that appears to be suspicious, contact Benefit Integrity/PSC and pend the application until directed otherwise.

4. Gender information is to assist in uniquely identifying the applicant. If the applicant fails to provide this information, contact the applicant by telephone, see §14.1.

5. Year of Graduation and Medical School. Verify this information with *Qualifier.net*. A physician does not need to provide *a copy of his/her diploma unless the contractor requests it.*

B - Correspondence Address

Check to see whether the applicant is changing previous information. If yes, make sure that the effective date is listed. If the applicant fails to provide an effective date, request additional information; see §14.1.

This section is to assist contractors in contacting the applicant with any questions or concerns you have with the application, such as fraud or abuse. This must be an address where the contractor can directly contact the applicant to resolve any issues that may arise as a result of his/her enrollment in the Medicare program. It cannot be an address of a billing agency, management services organization, or staffing company. It can be the individual's home address and telephone number.

Verify that the telephone number on the application is a number where the contractor can directly contact the applicant. Call the number on the application to verify that this is the applicant's personal number. If it is an answering service and the contractor can identify it as the applicant's personal service, it is not necessary to talk directly to the applicant. Contractors only need to verify, if necessary, that you are able to directly contact the applicant. If the applicant has not provided the contractor with this information, attempt to contact the person by telephone at his/her practice location. If contractors cannot make contact with the applicant, request additional information; see §14.1. If contractors find that the applicant has noted a billing agency's address, attempt to contact the applicant at the practice location. If contractors are unable to reach the applicant directly, request additional information; see §14.1.

C - Residency Status

Check to see whether the applicant is changing previous information. If yes, make sure that the effective date is listed. If the applicant fails to provide the contractor with an effective date, request additional information; see §14.1.

1. If the applicant checks the box "resident" or "intern" or "fellowship *program*" at a hospital, refer to Part 3 MCM, §2020.8 for further instructions. If this is missing, continue to process the application under the assumption that it does not apply, unless there is a reason to question the

data. If contractors believe that there is reason to question the information, request additional information; see §14.1.

2. If the applicant responded "Yes" to question 1, the applicant must answer the questions in this section.

3. If the applicant responded "Yes" to question 1, the applicant must answer the questions in this section.

4. If the applicant responded "Yes" to question 1, the applicant must answer the questions in this section.

D - Business Information (if applicable)

Check to see whether the applicant is changing previous information. If yes, make sure that the effective date is listed. If the applicant fails to provide contractors with an effective date, request additional information; see §14.1.

This section only needs to be completed if the applicant is practicing business under a name different from his/her individual name. If the information is missing, assume this does not pertain to the applicant.

1. If the applicant checks this section, continue to process the application.

2. Contractors need not verify the Legal Business Name and Tax Identification Number, as this data will be captured on the CMS-855B.

3. If an applicant indicates that he/she is incorporated, ask the applicant to complete the Form CMS-855B. This is the form *used* to enroll the individual's business. The applicant must also complete a Form CMS-855R to reassign his/her benefits to the business. Failure to complete the Form CMS-855B and Form CMS-855R will require contractors to enroll the applicant as an individual only. The business will not receive its own group number. If the applicant indicates that he/she is NOT incorporated but is a sole-proprietor, he/she only needs to indicate the business name on the Form CMS-855I. A sole proprietor does not need to complete the ownership portion of the application nor does it need to complete the Form CMS-855B form and Form CMS-855R. Verify that the entity is not incorporated if it is listed as a sole-proprietor.

NOTE: For purposes of this question, limited liability companies and limited liability corporations shall be treated as corporations.

E - Medical Specialty(s)

Check to see whether the applicant is changing previous information. If yes, make sure that the effective date is listed. If the applicant fails to provide contractors with an effective date, request additional information; see §14.1.

Verify that the applicant is licensed to practice in all States/counties for which a business/practice location is shown. This also includes medical and professional licenses, as well as Federal/State/local business requirements, if applicable. For a non-physician practitioner who is not required to be licensed in the state for whom CMS has additional requirements, instruct the applicant of the necessary documentation required. Failure to meet the licensing or documentation requirements will result in a denial; see § 14.3, denial 2. For those specialties that require special educational requirements that the applicant does not meet, deny the application; see §14.3, denial 4.

If an applicant submits the license without it being notarized or "certified true," contractors must verify the license with the appropriate state agency or Qualifier.net if available. All applicable business and professional licenses must be submitted and verified as valid, as well as Federal/State/local business requirements, if applicable. *Note that if Qualifier.net verified the applicant's licensure, contractors need not obtain a copy of the applicant's license. The Qualifier.net verification is sufficient.* If the state has a licensing body that issued the applicant a certificate of good standing, contractors can recognize it as adequate proof that an individual has received the license. However, the certificate of good standing cannot be older than 30 days.

A notarized copy of an original document will have a stamp which states "official seal" along with the name of the notary public, State, county, and the date the notary's commission expires. A certified "true copy" of an original document obtained from where it originated (or stored) has a raised seal that identifies the state and county in which it originated or is stored.

If the applicant had a previously revoked or suspended license, certification or registration reinstated, require that the applicant submit a copy of the reinstatement notice(s) with the application. If a supplier submits a temporary license, note the expiration date. If the applicant fails to submit the permanent license after the temporary license expiration date, request additional information. Inactivate the billing number until all the required licenses are obtained and notify the supplier of this action.

Professional School Degrees or Certificates--Verify all the required educational information *to ensure* that it is complete and accurate for non-physician practitioners. The non-physician practitioner must meet all CMS requirements for education and must provide documentation of courses or degrees taken to satisfy Medicare requirements. If contractors find that the applicant does not meet educational requirements, deny the application; see §14.3, denial 2. A physician's state medical license is acceptable proof of meeting educational requirements.

1. Physician Specialty - Check to see whether the applicant is changing previous information. If yes, make sure that the effective date is listed. If the applicant fails to provide contractors with an effective date, request additional information; see §14.1. The physician must indicate his/her supplier specialty, showing "P" for primary and "S" for secondary. The physician must meet the requirements of the specialty indicated on the Form. If needed, instructions can be found in Part 3-MCM, §2207. If the applicant fails to provide contractors with a supplier specialty, continue to process the application but request additional information if contractors are unable to determine the correct specialty code; see §14.1. Any time the individual does not meet the requirements of the specialty indicated on this form, deny the application; see §14.3, denial 2.

2. Non-Physician Specialty - Check to see whether the applicant is changing previous information. If yes, make sure that the effective date is listed. If the applicant fails to provide contractors with an effective date, request additional information; see §14.1. The non-physician practitioner must indicate his/her specialty showing "P" for primary and "S" for secondary. If needed, instructions can be found in Part 3-MCM, §2207. If the applicant fails to provide contractors with a supplier specialty, continue to process the application but request additional information if contractors are unable to determine the correct specialty code. See §14.1. Anytime the individual does not meet the requirements of the specialty indicated on this form, deny the application; see §14.3, denial 2.

A Nurse Practitioner (NP) who applies for a Medicare billing number for the first time on or after January 1, 2001, must be a registered professional nurse who is authorized by the state in which services are furnished to practice as a NP in accordance with state law and must be certified as a NP by a recognized national certifying body that has established standards for NPs. A NP who applies for a Medicare billing number for the first time on or after January 1, 2003, must meet the requirements stated in the previous sentence and must possess a Master's degree in nursing.

Enhanced qualifications for NPs only apply to those NPs applying for Medicare numbers for the first time on or after their effective date. Enhanced qualifications will not be required for NPs already enrolled in the Medicare program on the effective date of that enhanced qualification. For NPs previously enrolled in another carrier's jurisdiction, contractors must check the UPIN registry to verify their initial enrollment date prior to requiring they meet any of the enhanced qualification.

Diabetes Education, also known as Diabetes Self-Management Training or DSMT

Carriers are instructed that any provider/supplier already enrolled with them that wishes to bill for DSMT need not submit a new Form CMS-855B. Rather the provider/supplier need only submit the American Diabetes Association (ADA) certificate (or other CMS-recognized certification). If the provider/supplier is not enrolled with contractors (e.g., is a DMEPOS supplier only; is a supplier enrolled only with another carrier), it must complete a new Form CMS-855B.

Since DMERCs cannot pay DSMT claims, a DMEPOS supplier must separately enroll with its local Part B carrier, even if it has already completed a Form CMS-855S and is enrolled in the Medicare program. In order to file claims for diabetes education services, a DMEPOS supplier must also be certified by a CMS-approved national accreditation organization, or during the first 18 months after the effective date of the final rule, recognized by the ADA as meeting the national standards for DSMT as published in Diabetes Care, Volume 23, Number 5.

If contractors receive an application from a DMEPOS supplier *that would like to bill for DMST*, verify with the *National Supplier Clearinghouse* (NSC) that the applicant is currently enrolled and eligible to bill the Medicare program. Contractors can do this through Email using the following address: Medicare.nsc@palmettogba.com. Provide the contractor's Email address, the supplier's name, National Supplier Clearinghouse number, and tax identification number. Once the information is confirmed, contractors will receive a response from the NSC. If the applicant

is an approved supplier and enrolled with the NSC, process the application in accordance with Chapter 10. Enroll the DMEPOS supplier using specialty code 87 to allow claims to be processed.

F - Supervising and/or Collaborating Physician – For those specialties that require a supervising and/or collaborating physician to qualify to bill the Medicare program, the applicant must list the physician(s) in this section. Verify that any physician shown has not been sanctioned/excluded from the Medicare program *through Qualifier.net*. If the supervising and/or collaborating physician is excluded, deny the application; see § 14.3, Denial 1. All supervising and/or collaborating physicians must be enrolled individually.

***G* - Clinical Psychologist** – Questionnaire--All questions must be answered to *determine the applicant's eligibility to bill Medicare.*

1. *If the applicant does not hold a doctoral degree in psychology, deny the application; see §14.3, Denial 4.*

There are three different types of doctoral degrees in psychology that meet Medicare's requirements.
The first and most common is the Ph.D. or doctorate of philosophy degree. The critical factor is that the Ph.D. must be in psychology (as opposed to any other subject area). If this is the case, contractors may accept the diploma as sufficient evidence. If the diploma does not state "Doctor of Philosophy" followed by some specific subject area of psychology, follow instructions regarding contact with state licensing board or collect transcript information from the applicant.

The second type of doctoral degree that meets Medicare's requirement is the Psy.D. or doctorate of psychology degree. This degree is granted by programs that lean more heavily towards preparing students for clinical practice rather than research or teaching.

The third doctoral degree that would qualify as a doctoral degree in psychology for Medicare enrollment is the Ed.D. or doctorate of education degree. Again, the critical factor is that the person's Ed.D. must be in psychology. To illustrate, having an Ed.D. in counseling psychology would qualify someone to seek CP status, but having an Ed.D. in educational administration or curriculum design would not. If the diploma does not state "Doctor of Education" followed by some specific subject area of psychology, follow instructions regarding contact with state licensing board or collect transcript information from the applicant.

If the diploma does not indicate the specialty, there are two ways that contractors can verify that the individual's doctorate is in psychology.

The first way is to check with the licensing board in each state to determine whether a doctorate in psychology is required to obtain a license to practice as a clinical psychologist. The majority of states require this level of education in order to practice psychology independently. If you find that the state does require a doctorate in psychology as a requirement for licensure as a Clinical Psychologist, contractors may take the fact that the applicant has a license, along with the copy of the diploma, as sufficient evidence that the applicant meets Medicare's educational

requirements for a clinical psychologist. This is the preferred method to verify that the applicant meets Medicare's educational requirements. If contractors choose this method of verification, each carrier must document in its procedures that the state licensure requirements for clinical psychologist require a doctorate in psychology. This way contractors do not need to develop for this additional information each time contractors receive a diploma that does not clearly state the area of study.

The second way is to request the applicant submit a graduate school transcript showing the concentration of study. The carrier must then review the transcript and make a subjective decision as to whether the program of study is focused in psychology. This is the least preferred method of verifying the applicant's education as it requires review of the academic transcript and determination of a field of study for each doctoral degree diploma which does not identify the specialty area.

2. If the applicant does not agree to inform each Medicare beneficiary of the desirability to confer with the beneficiary's primary care physician regarding the beneficiary's medical condition, deny the application; see §14.3, Denial 4.

3. If the Medicare beneficiary assents to the consultation and the applicant does not agree to consult with the beneficiary's primary care physician in accordance with accepted professional ethical norms, deny the application; see §14.3, Denial 4.

4. If the Medicare beneficiary assents to the consultation and the applicant does not agree to consult with the beneficiary's primary care physician within a reasonable time, deny the application; see §14.3, Denial 4.

H. - **Psychologists Billing Independently** - Questionnaire--All questions must be answered in this section *to determine the applicant's eligibility to bill Medicare.*

1. If the Psychologist indicates that he/she does not render services free of the professional control of an employer such as a physician, institution or agency, deny the application; see §14.3, Denial 4.

2. If the applicant does not treat his/her own patients deny the application; see §14.3, Denial 4.

3. If the Psychologist indicates that he/she does not have the right to collect fees for the service rendered, deny the application; see §14.3, Denial 4.

4. If the Psychologist's private practice is located in an institution and he/she does not furnish services to patients in private office space maintained at his/her own expense, deny the application; see §14.3, Denial 4.

If the Psychologist submits changes to add a practice location(s), he/she must complete the Questionnaire.

5. If the Psychologist's private practice is located in an institution and he/she does not furnish services to patients other than the institution's patients, deny the application; see §14.3, Denial 4.

I - Occupational/Physical Therapist in Private Practice (OT/PT) - *If the OT/PT submits changes to add a practice location(s), he/she must complete the questionnaire.*

Questionnaire--If the applicant indicates that this is his/her specialty, he/she must respond to these questions. However, if an OT/PT plans to provide his/her services as a member of an established OT/PT group, *an employee of a physician directed group, or as an employee of a non-professional corporation,* and reassigns his/her benefits to that group, this section does not apply. This information will be established through the group application.

1. If the OT/PT checks that he/she renders all of his/her services in patients' homes, verify that he/she has an established private practice where he/she can be contacted directly and where he/she maintains patient records. Also, §4E of the Form CMS-855 should indicate where services are rendered (e.g., county, State, city of the patients' homes). Post office boxes are not acceptable.

2. If an applicant indicates that he/she does not maintain private office space, deny the application; see §14.3, Denial 4.

3. If the OT/PT does not own/rent/lease his/her space, deny the application; see §14.3., Denial 4.

4. If the OT/PT checks *"No" that office space is not used exclusively for its private practice* deny the application; see §14.3, Denial 4.

5. If the OT/PT checks "Yes" that he/she does provide services outside of his/her office or outside of a patient's home, e.g., health club, public pool, verify that the OT/PT has a copy of a lease agreement giving him/her the exclusive use of that facility to treat Medicare patients. If it does not, deny the application; see §14.3, Denial 4.

J. **- Physician Assistants (PA) Only** - Section 2F of Form CMS-855I addresses Supervising and/or Collaborating Physicians and pertains to all non-physicians practitioner (excluding PAs) who require a supervising and/or collaborating physician to qualify for Medicare billing privileges. Any reference to PAs in Section 2F Supervising and/or Collaborating Physician <u>is incorrect</u>. The reason Section 2F excludes PAs is because Section 2J has been designed to capture information regarding the physician identified on the PA's license or degree. *Since not all States require the name, SSN and date of birth on the PA's license, this information is not readily available. Also, a PA may not be aware who would be supervising/directing him/her. Therefore, we are not requiring that it be submitted on Form CMS-855I. If the applicant submits the information, determine if the name(s) appears on Qualifier.net or HIPDB. However, it is not necessary to develop for the information.*

If the applicant indicates that this is his/her specialty, the PA must provide all employer Medicare billing number(s) that will bill Medicare for his/her services. Review the section that shows who

plans to bill for the PA services. Any entity or individual who bills for the PA services must be a supplier and must be enrolled with the carrier.

A PA cannot bill the program. Therefore, a PA has no benefits to reassign. In order to reassign, contractors must be able to receive the payment directly. Only employers who are entitled to enroll as a supplier can receive the payment for a PA.

Section 2: Supplier Identification - Form CMS-855B

A. Type of Supplier

1. Check One

Verify that the supplier is licensed to practice, as the supplier type checked, in all States/counties in which it lists a business/practice location. This includes medical and professional licenses, as well as Federal/State/local business requirements, if applicable. The supplier must meet the requirements of the specialty indicated on the application, i.e., a professional medical license must match the specialty type chosen. If the supplier does not have the appropriate license, deny the application; see §14.3, Denial 2.

If the applicant submits the license without its being notarized or "certified true," contractors must verify the license with the appropriate state agency. Contractors must use Qualifier.net if this is available for the supplier type. All applicable business and professional licenses must be submitted and verified as valid, as well as Federal/State/local business requirements, if applicable. If the state has a licensing body that issued the applicant a certificate of good standing, contractors can recognize it as adequate proof that it has received the license. However, the certificate of good standing cannot be older than 30 days.

If the applicant had a previously revoked or suspended license, certification or registration reinstated, require that the applicant submit a copy of the reinstatement notice(s) with the application.
If a supplier submits a temporary license, note the expiration date in the data system. If the applicant fails to submit the permanent license after the temporary license expiration date, request additional information and inactivate the billing number until all the required licenses are obtained. Notify the applicant of this action.

Radiology Offices--Prior to enrolling a radiology group practice, see the enrollment section for IDTFs. The carrier shall determine that the radiology group practice qualifies as a radiologist's office. This is necessary to allow the group practice of radiologists to bill for the technical component (TC) of diagnostic tests. A discussion of the criteria for distinguishing between an IDTF and a radiologist's office is shown in the IDTF section of the manual.

Hospitals that are applying for billing numbers for practitioner services must check the appropriate box. The carrier shall follow the guidance provided in the section entitled, "Processing Hospital Form CMS-855s." The carrier does not have to obtain a copy of the state

license of the hospital. Notification that the hospital has received a provider agreement is adequate.

2. OT/PT Groups Questionnaire--If the *therapy* group, *physician directed group, or non-professional corporation* indicates that this is its specialty, it must respond to these questions. *When OT/PTs are enrolled in groups, the group must complete the Questionnaire when submitting a change to add Practice Location(s).*

a. If the group checks it renders services in a patient's home, verify that it has an established private practice where it can be contacted directly and where it maintains patients' records. Also, section 4E of *Form* CMS-855B must indicate where services are rendered; i.e., counties, states, city of the patients' homes.

b. When a group states that it does not maintain a private practice, deny the application; see §14.3, Denial 4.

c. Indicate if the group owns/rents/leases the space. If no, deny the application; see §14.3, Denial 4.

d. If the group checks *"No" that office space is not used exclusively for its private practice* deny the application; see §14.3., Denial 4.

e. If the *group* checks "Yes" that he/she does provide services outside of his/her office or outside of a patient's home, i.e., health club, public pool, verify that the OT/PT has a copy of a lease agreement giving him/her the exclusive use of that facility to treat Medicare patients.

3. If the supplier indicates that it will be receiving reassigned benefits from individual practitioners, verify that contractors have received a Form CMS-855R from each practitioner. Make sure that each practitioner has completed his/her own Form CMS-855I. If the supplier indicates "Yes" and a separate form is not received, continue to process the application but do not allow the entity to receive reassigned benefits from an individual until all the appropriate forms are completed.

4. Hospitals Only - A hospital enrolling with the carrier to bill for practitioner services must complete this section.

B. Supplier Identification Information

1. Verify that the legal business name reported is the same name reported on the IRS documentation that was submitted with the application. If the legal business name is different than what is reported to the IRS, request additional information for clarification after contractors have finished reviewing it; see §14.1. Verify the date the business started. If contractors find a discrepancy, contact the applicant for additional information; see §14.1.

2. Capture the "doing business as" name as reported and the county/parish where the name is registered (if applicable).

3. Note the organizational structure for this supplier in the contractor's system.

4. Verify the incorporation date. Contractors can do this using Qualifier.net. If contractors find a discrepancy, contact the applicant for additional information; see §14.1. Contractors may request a copy of the supplier's "Articles of Incorporation" for validation purposes if contractors uncover a discrepancy.

C. Correspondence Address

This section is to assist contractors in contacting the applicant with any questions or concerns about the application. This must be an address where contractors can directly contact the applicant to resolve any issues that may arise as a result of its enrollment in the Medicare program. It cannot be an address of a billing agency, management services organization, or staffing company.

Verify that the telephone number on the application is a number where contractors can directly contact the applicant. Call the number on the application to verify that this is the applicant's personal number. If it is an answering service, and the contractor can identify it as the applicant's personal service, it is not necessary to talk directly to the applicant. Contractors only need to verify, if necessary, that contractors are able to directly contact the applicant. If the applicant has not provided contractors with this information, attempt to contact the person by telephone at his/her practice location. If the contractor cannot make contact with the applicant, request additional information; see §14.1. If contractors find that the applicant has supplied a billing agency's address, try to contact the applicant at the practice location. If the contractor is unable to reach the applicant directly, request additional information.

D. Accreditation (Ambulatory Surgical Centers (ASCs) Only)

Check to see whether the applicant is changing previous information. If yes, make sure that the effective date is listed. If the applicant fails to provide contractors with an effective date, request additional information; see §14.1.

1. Note if the ASC has been approved by an accredited organization in lieu of a state Agency.

2. Annotate the date accreditation was received. If this date is after the date it started business, notify the claims department. No claims can be paid prior to the date the entity received its accreditation.

3. Note the name of the accrediting body or organization.

3.3 - Adverse Legal Actions(s) – (Rev. 41, 05-23-03)

Section 3. Adverse Legal Actions and Overpayments - Form CMS-855I and Form CMS-855B

A. Adverse Legal History

Check to see whether the applicant is changing previous information. If yes, make sure that the effective date is listed. If the applicant fails to provide contractors with an effective date, request additional information; see §14.1.

1. The applicant must respond to this question, either checking "Yes" or "No." If the applicant indicates that it has had an adverse legal action imposed against it but Qualifier.net (which contains GSA and MED data) does not report this, contact the OIG and/or Benefit Integrity/PSC to determine whether this can and should form the basis of an exclusion. Hold (but continue processing) the application until the OIG decides whether the adverse legal action should result in an exclusion. If the OIG imposes an exclusion, deny the application. If not, continue processing the application. However, based on the findings of Benefit Integrity/PSC the contractor may want to flag this applicant's claims for future review.

Check the name, tax identification number, and/or Medicare numbers against Qualifier.net, FID (if applicable) and HIPDB. (Qualifier.net shall be used to check the MED and GSA monthly "List of Parties.") The applicant (individual or supplier) must be checked against the aforementioned databases regardless of whether it states in this section that it has never had an adverse legal action imposed against it. If the applicant is excluded or debarred, process the application to capture all the information in the enrollment system but then deny the application; see §14.3, denial 1.

Contact any other carriers that may have enrolled the applicant to ensure that no future payments are made, that the other carriers are aware of the exclusion, and that recoupment actions are taken if appropriate.

The Fraud Investigation Database (FID) must be checked for all applicants, managers, directors/owners, etc. when it is noted that the above individuals/entity has or has had a Medicare identification number. Therefore, if there is no indication that the individuals/entity ever had a billing number, do not check the FID. If the applicant states that it has never had a Medicare identification number but the contractor finds it has, contractors must check the FID. If the applicant appears on the FID but is not excluded, process the application according to §16.1.

If the applicant appears in the HIPDB, process the application according to §16.2

2. If the applicant indicates that it has had an adverse legal action imposed against it, make sure that the applicant provides information concerning the type and date of the action and what court(s) and law enforcement authorities were involved. Also, documentation that shows the imposition, notification, and resolution of the adverse action must be submitted. Refer the application to Benefit Integrity/PSC for further investigation. If the applicant was excluded but has since been reinstated, verify this through the OIG and ask the applicant to submit written proof (e.g., reinstatement letter) indicating that such reinstatement has in fact taken place. *Anytime an applicant is being reinstated, make sure that the applicant responds "yes" to this*

question. Failure to respond appropriately to this question would result in a denial. See Denial 8 in §14.3.

Table A

This table is a list of all adverse legal actions that must be reported in Section 3A of the application. This table is to be used for all applicants, 5% or more owners, managing employees, Partners, authoriz*ed* officials, etc.

If one or more adverse legal actions is listed for the applicant, and has not resulted in an exclusion, refer this application to Benefit Integrity/PSC for further investigation.

B. Overpayment Information

If the applicant indicates that it has outstanding Medicare overpayments, initiate procedures for collection. The applicant must furnish the name or business identity under which the overpayment occurred and the account number under which the overpayment exists. Note that overpayments that occur after the supplier is enrolled need not be reported unless the supplier is enrolling with a new
Medicare contractor.

3.4 - Practice Location – (Rev. 41, 05-23-03)

Section 4: Practice Location - Form CMS-855I

Verify that the practice locations listed on the application actually exist. Contractors must use Qualifier.net to verify *if the information on the application is* a good address. *If for some reason the information is not shown on the executive summary, the contractor can make a telephone call directly to the applicant requesting additional information. For example, the carrier could request that the applicant provide letterhead showing the appropriate address if it wasn't available in Qualifier.net.* If *the address* do*es* not exist, deny the application; see §14.3, Denial 3, Individual Application

A. Group Practice Information

This section is used to determine if the individual plans to render services in a group setting. If yes, make sure that the applicant has provided the contractor with a Form CMS-855R for every group to which the individual plans to reassign benefits. Also, verify that the group has been enrolled in the Medicare program.

1. If an individual plans to render all of his/her services in a group setting, he/she must check this section. Also, the individual must provide the name of the group (a) and the group's Medicare number in the space provided. If the individual is affiliated with more than three groups, he/she must copy this page to list any additional group affiliations. If the group has not yet been enrolled, contractors must first enroll the group prior to approving the reassignment. Once the applicant has provided the contractor with this information, he/she must complete §15.

2. If an individual is only rendering Part of his/her services in a group setting, he/she would complete this section. The applicant would list the group's name (a) that he/she has *an* affiliation with and its Medicare number in the space provided. Require that the applicant provide a Form CMS-855R for every group to which he/she plans to reassign benefits. Verify that the group has been enrolled in the Medicare program. If the group has not been enrolled, contractors must first enroll the group prior to approving the reassignment.

B. Practice Location Information

Check to see whether the applicant is adding, deleting, or changing previous information. If he/she is, make sure that the effective date is listed. If the applicant fails to provide contractors with an effective date, request additional information; see §14.1.

1. Indicate where services are rendered, including all hospitals and/or other health care facilities in this section. The practice name can be a "Doing Business As Name". Date Started at this Location.--Use this date as the date the applicant can begin to bill the program following approval after determining the applicant had a license prior to that date. In situations where the date appears to be beyond a reasonable amount of time, such as older than 12 months, contact the applicant by telephone. Ask the applicant to provide contractors a date that he/she started seeing Medicare patients. Contractors need to ensure the 12 month deactivation initiative will not remove the new applicant from the file for any date that is used. If this information is missing, request it in writing.

2. The applicant *must* list each address where services are rendered, including all hospitals and/or other health care facilities in this section. A practitioner who renders services only in patients' homes (house calls) must supply his/her home address in this section. If an individual practitioner renders services in a retirement or assisted living community, this section must be completed by using the names and addresses of those communities. Verify that these addresses are physical addresses. Post office boxes and drop boxes are not acceptable for these addresses. If contractors are unable to verify the address, deny the application according to §14.3, Denial. 3. If all the information is not provided, see procedures in §14.1 and request additional information. Verify this information through Qualifier.net. Also verify that the telephone number reported is operational and connects to the practice location/business that is listed on the application. The telephone number must be a number where patients and/or customers can reach the applicant to ask questions or register complaints. 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 practice locations are in the contractor's jurisdiction and he/she maintains no operable telephone number at those practice sites or if he/she operates a mobile Unit. Match the applicant's telephone number with known, in-service telephone numbers using Qualifier.net to correlate telephone numbers with addresses. If contractors cannot verify the telephone number, complete the application verification process and request corrected information. If contractors suspect fraud or abuse, contact Benefit Integrity/PSC. The inability to confirm a telephone number may be an indicator to do an onsite visit. If contractors have an applicant who is using a cell phone for their business, contractors must verify that this is a telephone connected directly to its business.

3. For those individuals who are receiving reassigned benefits from contractors, indicate if he/she owns or leases the practice location. For those who received reassigned benefits from contractors-follow instructions as written in PART 3 MCM 3060.

4. Annotate if the practice location is any of the *locations* listed.

5. The applicant must list any CLIA or FDA Mammography Certification Numbers (if applicable). If the applicant fails to provide contractors with the certification number, and the contractor is aware that he/she does have one, request additional information. See §14.1. If the applicant provides contractors with an incorrect number request additional information/clarification.

C. Medicare Payment "Pay To" Address Information

If an applicant indicates that payments are going to an address other than the reported *practice location* address, update the system. This address may be a post office box. If *payment is being made to an agent, verify that the billing agreement/contract information questions in Section 8C of Form CMS-855 are appropriately answered. If the response to questions in Section 8C give rise to questions or concerns, the contractor must request a copy of all agreements/contracts associated with this billing agency.* If the payments are being sent electronically, verify that an Electronic Funds Transfer (EFT) Authorization Agreement has been signed. When an EFT Authorization agreement is submitted, verify the bank account is in compliance with Part 3 MCM 3060.11, Payment to Bank. Anytime a change is made to the EFT Authorization agreement, the provider enrollment staff must review this change to verify it complies with 3060.11.

If a provider submits Form CMS-855 (along with *Form CMS*-588) and states he/she is using EFT and later notifies the contractor's accounting department that he/she is changing their account to a different bank, the provider enrollment staff would need to be involved. The accounting department must forward the new *Form CMS*-588 form to the provider enrollment staff. The PE staff must review *Form CMS*-588 to *determine whether* all banking information complies with MCM §3060.11. *We view a change to Form CMS-588 as a change to the pay-to-address. If the contractor's accounting department notifies PE staff that they received a Form CMS-588, and the supplier has never completed an enrollment application, he/she must complete one. Although Form CMS-855 may not reflect the above change in the pay-to-address section of the form, as this address may be used for hardcopy checks and remittance advices, contractors must verify/validate the managers/owners, legal business name, signatures, etc. Therefore, it is necessary to obtain a new Form CMS-855. If, however, the supplier has completed an enrollment form, the contractor must check the signature on Form CMS-588 form against signatures on the Form CMS-855 on file. A new Form CMS-855 is not necessary. All the validation requirements as listed below must be followed.* Once verifications are complete, a copy of the Form *CMS*-588 must be attached to the existing *(or new)* Form CMS-855 on file. The *original Form CMS*-588 can be maintained in accounting.

For those applicants who request a change to the "Pay To" address, we are requiring carriers to examine closely any request for an address change to ensure that the request is from the supplier in question. *For a change to* a "Pay To" address, the carrier must follow these procedures:

1. If the applicant *has never* completed an entire Form *CMS-855* the contractor shall request that he/she complete an entire Form *CMS-855 reflecting the request to change the "Pay To" address.* Verify and validate all the information provided.

2. Check billing records to determine if the supplier has billed the program within 3 months. If the supplier has billed the program, continue with the next step. If the supplier has had no billing activity within 3 months, contact Benefit Integrity/Program Safeguard Center (PSC) to determine if there has been any suspicious conduct or activity. The Benefit Integrity/PSC must verify that this is an appropriate change. If it is determined that this request appears to be legitimate, continue with the processing of the application. Of course if the change appears to be suspicious, the Benefit Integrity/PSC will pursue as necessary and pend the application. Any time a supplier has been deactivated for-nonbilling, he/she will be required to verify that the enrollment data on file is still current/valid.

If the applicant was previously enrolled using Form *CMS-855*, verify the signature on the Form CMS-855 reflecting the change in the "Pay To" address against the existing signature to make sure that they match. When the applicant requests a telephone number change at the practice location with a change to the "Pay To" address, call the number listed on the contractor's supplier file first. If the number on file is still active, attempt to speak with the supplier/authorized representative/delegated official who requested the change to verify the validity of the change. If contractors receive a directory assistance message changing the old number to a new number, and that number matches the supplier's request for change, contact the supplier at the new number. Inform the supplier you are making sure that this is a legitimate request for change. Although the enrollment unit may not always be able to reach the supplier directly, make every attempt to speak with the supplier/authorized representative/delegated official and not a staff member. If the supplier cannot be reached or a telephone number change seems suspicious, annotate the file and contact Benefit Integrity/PSC. If the change appears to be legitimate, continue with the update.

The carrier must follow the Do Not Forward initiative instructions as communicated in Transmittal B-02-023, CR 2038. These changes require a Form CMS-855I/B be submitted reflecting a change to the "Pay to" address (a complete Form CMS-855 if none is on file) and should not be processed based solely upon a letter from the enrolled entity "requesting a change to the "Pay To" address. In situations where a provider/supplier is closing his/her business and has a termination date, i.e., he/she is retiring, the contractor will still need to make payment for prior services rendered. Since the practice location has been terminated, the contractor may encounter a DNF message. In these situations, contractors can request the retired physician to complete the Pay-to-address section of the Form CMS-855 along with the certification statement. Do not collect any other information unless you have a need to do so.

D. Location of Patient Records.

Check to see whether the applicant is changing previous information. If yes, make sure that the effective date is listed. If the applicant fails to provide contractors with an effective date, request additional information; see §14.1.

The applicant must report where records are kept for each practice location. If the records are kept at the practice location shown in §4B, the applicant can skip this section. If the address is different than that of a practice location, indicate where the records are stored.

If the applicant does not have a place where he/she stores records, the application must be denied according to §14.3, Denial 3. Records kept at a storage location must be indicated. If the applicant leaves this section blank, see procedures in §14.1 and request additional information. Post office boxes and drop boxes are not acceptable as the physical address where patient records are maintained.

E. Comments

This section is used to capture any unique or unusual circumstances concerning the supplier's practice location(s) or the method by which the supplier renders health care services. Contractors must determine that the information provided is acceptable under current Medicare rules and is accurate.

Section 4: Practice Location - Form CMS-855B

A. Practice Location

Check to see whether the applicant is adding, deleting, or changing previous information. If yes, make sure that the effective date is listed. If the applicant fails to provide contractors with an effective date, request additional information; see §14.1.

1. The applicant must list each location where services are rendered, including all hospitals and/or other health care facilities in this section. The practice name can be the "Doing Business *As* Name."

Date Started at this Location. --Use this date as the date the applicant can begin to bill the program following approval. Be sure to determine, however, *that* the applicant had a license prior to that date. In situations where the date appears to be beyond a reasonable amount of time, such as older than 12 months, contact the applicant by telephone. Ask the applicant to provide a date that he/she started seeing Medicare patients. Contractors need to ensure the 12-month deactivation initiative will not remove the new applicant from the file for any date that is used. If this information is missing, request it in writing.

2. Verify that the address(es) listed *is/*are physical addresses. Post office boxes and drop boxes are not acceptable for those addresses. Contractors cannot just make a telephone call to validate this information. At the very least, use Qualifier.net to verify a good address to help make this determination--as well as telephone the applicant's number. If contractors are unable to verify the address, deny the application according to §14.3, Denial 3. If information is not provided, see

procedures in §14.1 and request additional information. Match the applicant address with known addresses using Qualifier.net.

NOTE: *For Ambulatory Surgical Centers (ASCs) and Portable X-ray suppliers if the applicant's address and or telephone number cannot be verified by use of Qualifier.net, then contact the applicant. If they advise that the facility and its phone number have not yet been completed, continue processing the application and annotate the file. However, a note shall be placed on any recommendation for approval that the address and the telephone number of the facility could not be verified pending completion of the facility. In this case, the Date Started at this Location item can also be left blank. For PECOS entry, when available, put in the date that the Certification Statement was signed, for the practice location start date. Don't pay claims until the notification that the supplier meets the certification requirements have been received. For IDTFs if the applicant's address and or telephone number cannot be verified by use of Qualifier.net, then contact the applicant. If they advise that the facility and its phone number have not yet been completed, continue processing the application. These items shall be checked at the required site visit. The same guidance concerning address and telephone number verifications for ASCs, portable-x-ray suppliers, and IDTFs stated above shall apply if the applicant utilizes a Base of Operations for its practice location information.*

Contractors can verify through contact with the appropriate state agency or Qualifier.net, if needed, the date incorporated or established as identified by the supplier on the application. Match the applicant's telephone number with known, in-service telephone numbers using industry-recognized software. The software must correlate telephone numbers with addresses. The telephone number must be a number where patients and/or customers can reach the applicant to ask questions or register complaints. 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 practice locations are in the contractor's jurisdiction and he/she maintains no operable telephone number at those practice sites. If contractors cannot verify the telephone number, complete the application verification process and request corrected information.

If the group is using a cell phone, contractors must conduct further investigations as to why it would conduct business this way. If contractors need further guidance, contact the RO.

3. For an entity that is receiving reassigned benefits from contractors, determine if the entity owns or leases the practice location. For those who received reassigned benefits from *independent* contractors, determine it meets criteria as instructed in the PART 3 MCM 3060.

4. The applicant must list any CLIA or FDA Mammography Certification Numbers (if applicable).

B. Mobile Facility and/or Portable Units

Check to see whether the applicant is changing previous information. If yes, make sure that the effective date is listed. If the applicant fails to provide contractors with an effective date, request additional information; see §14.1.

If the applicant indicates that *it* is providing services from a mobile facility or portable unit, *it must* complete section 4C through 4E about the mobile/portable services on the Form CMS-855B. If the applicant fails to check this box, continue to process the application and assume *it* does not operate services from a mobile facility or portable unit. However, if contractors suspect something different, contact the applicant for additional information; see §14.1.

C. Base of Operations Address

Check to see whether the applicant is changing, adding, or deleting previous information. If yes, make sure that the effective date is listed. If the applicant fails to provide contractors with an effective date, request additional information; see §14.1.

1. If the supplier answered "yes" in B, the base of operations name and the date the supplier started practicing at this location must be captured in this section. If the applicant fails to provide contractors with this information, request additional information; see §14.1.

2. This address must be one *from* where the personnel are dispatched, where the mobile/portable equipment is stored and when applicable, where vehicles are parked when not in use. The telephone number, fax number and applicable E-mail address must be captured for the base of operations. If the applicant fails to provide contractors with this information, deny the application according to §14.3, Denial 3.

D. Vehicle Information

Check to see whether the applicant is changing previous information. If yes, make sure that the effective date is listed. If the applicant fails to provide contractors with an effective date, request additional information; see §14.1.

This section captures information about the mobile unit when services are rendered in the vehicle. For portable services (e.g., where the equipment is removed from a van, etc., and is used in a fixed setting), information concerning how the equipment was transported would not be captured in this space. If this section is blank, assume that the services are not rendered inside a vehicle unless contractors have data that shows that they are providing medical services inside a vehicle. If contractors find this, *request additional information. If none is forthcoming,* deny the application according to §14.3. Denial 3.

1-3. Capture the vehicle information. A copy of all health care related permit(s), license(s), and registration(s) must be submitted for each vehicle reported. If the applicant fails to provide contractors with this information, deny the application according to §14.3, Denial 3 *unless contractors are able to verify this information through Qualifier.net (See §14 for additional information*.)

E. Geographic Location where the Base of Operations and/or Vehicle Renders Services

Check to see whether the applicant is changing previous information. If yes, make sure that the effective date is listed. If the applicant fails to provide contractors with an effective date, request additional information; see §14.1.

1. Initial Reporting and/or Additions

This section captures where the supplier renders services to Medicare beneficiaries in its mobile unit. For those mobile units that cross state lines, the supplier must complete a separate Form CMS-855 enrollment application for each carrier jurisdiction *in which* it provides services. If the applicant fails to provide contractors with this information, request additional information.

2. Deletions

The applicant would provide contractors this information if *it* is deleting a location where mobile or portable services were provided.

F. Pay-to-Address

If an applicant indicates that payments are going to an address other than the reported *practice location* mailing address, *place that information into PECOS.* This address may be a post office box. If contractors determine that contractors are making payment to an agent, *(See Section 8 of the application)* determine that billing agreement follows all the requirements outlined in the Medicare Carriers Manual (MCM), Part 3, §3060. If the payments are being sent electronically, verify that an EFT agreement has been signed *by the appropriate official shown on Form CMS-855B.* When an EFT agreement is submitted, verify the bank account is in compliance with the PART 3 MCM 3060, Payment to Bank.

Electronic Funds Transfer Changes

If a supplier submits *Form* CMS-855 (along with *Form CMS*-588) and states he/she is using EFT and later notifies the contractor's accounting department that he/she is changing their account to a different bank, the provider enrollment staff would need to be involved. The accounting department must forward the new Form *CMS*-588 to the provider enrollment staff. The PE staff must review the Form *CMS*-588 to *determine whether* all banking information complies with the MCM, §3060.11. *We view a change to Form CMS-588 as a change to the pay-to-address. If the contractor's accounting department notifies PE staff that they received a Form CMS-588, and the supplier has never completed an enrollment application, he/she must complete one. When completing a Form CMS-855, the EFT address may not be reflected in the pay-to-address section of the form, as this address may be used for hardcopy checks and remittance advices. However, contractors must verify/validate the managers/owners, legal business name, signatures, etc. Therefore, it is required to obtain a new Form CMS-855. If, however, the supplier has completed an enrollment form, the contractor need only to check the signature on the Form CMS-588 against signatures on the Form CMS-855 on file. A new Form CMS-855 is not necessary. All the validation requirements listed below must be followed.* Once verifications are complete, a copy of the Form *CMS*-588 must be attached to the existing *(or new) Form* CMS-855 on file. The *original Form CMS*-588 can be maintained in accounting.

For those applicants who request a change to the "Pay To" address, we are requiring carriers to examine closely any request for an address change to ensure that the request is from the supplier in question. *For a change to* a "Pay To" address, the carrier must follow these procedures:

1. If the applicant has never completed an entire Form CMS-855 the contractor shall request that he/she complete an entire Form CMS-855 reflecting the request to change the "Pay To" address. Verify and validate all the information provided.

2. Check billing records to determine if the supplier has billed the program within 3 months. If the supplier has billed the program, continue with the next step. If the supplier has had no billing activity within 3 months, contact *Benefit Integrity/PSC to determine if there has been any suspicious conduct or activity. The Benefit Integrity/PSC must* verify that this is an appropriate change. If it is determined that this request appears to be legitimate, continue with the processing of the application. Of course if the change appears to be suspicious, the Benefit Integrity/PSC will pursue as necessary and pend the application. Any time a supplier has been deactivated for-nonbilling, he/she will be required to verify that the enrollment data on file is still current/valid.

If the applicant was previously enrolled using Form *CMS-855*, verify the signature on *Form* CMS-855 reflecting the change in the "Pay To" address against the existing signature to make sure that they match. When the applicant requests a telephone number change at the practice location with a change to the "Pay To" address, call the number listed on the contractor's supplier file first. If the number on file is still active, attempt to speak with the supplier/authorized representative/delegated official who requested the change to verify the validity of the change. If the contractor receives a directory assistance message changing the old number to a new number, and that number matches the supplier's request for change, contact the supplier at the new number. Inform the supplier you are making sure that this is a legitimate request for change. Although the enrollment unit may not always be able to reach the supplier directly, make every attempt to speak with the supplier/authorized representative/delegated official and not a staff member. If the supplier cannot be reached or a telephone number change seems suspicious, annotate the file and contact Benefit Integrity/PSC. If the change appears to be legitimate, continue with the update.

The carrier must follow the "Do Not Forward" initiative instructions as communicated in Transmittal B-02-023, CR 2038. These changes require a Form CMS-855I/B be submitted reflecting a change to the "Pay to" address and should not be processed based solely upon a letter from the enrolled entity "requesting a change to the "Pay To" address."

G. Location of Patient Records

1. The applicant must report where records are kept for each practice location. If the records are kept at the practice location shown in Section 4Aor 4C, the applicant can skip this section.

2. If the address is different than that of a practice location, indicate where the records are stored.

If applicant does not have a place where *it* stores records, the application must be denied according to §14.3, Denial 3. Records kept at a storage location must be indicated. If the

applicant leaves this section blank, request additional information. Post office boxes and drop boxes are not acceptable as the physician address where patient records are maintained. All record requirements must be in conformance with Medicare regulations governing the reopening of a claim/cost report, etc.

H. Comments

This section is used to capture any unique or unusual circumstances concerning the supplier's practice location(s) or the method by which the supplier renders health care services. Contractors must determine that the information provided is acceptable under current Medicare rules.

3.5-Ownership and Managing Control Information (Organizations) – (Rev. 41, 05-23-03)

Section 5: Managing Control Information (Organizations) - Form CMS-855I

The individual practitioner must furnish information about any organization that manages his/her practice. For purposes of this section, a managing organization is defined as any organization that exercises operational or managerial control over the practitioner's business/practice, or conducts the day-to-day operations of the practitioner's business/practice. The organization can be a management services organization that, via contract or some other arrangement, provides management services for any of the practitioner's business/practice locations.

NOTE: No information on ownership should be reported in this section.

A. Check Box

This box must be checked if there are no organizations that manage the practitioner's business. If the applicant fails to check this box and does not list any managing organization, contact the applicant to request additional information; see §14.1.

B. Identification Information

Check to see whether the applicant is adding, deleting, or changing information about an existing managing organization. If one of these boxes is checked, make sure that an effective date is listed. The legal business name, "Doing Business As" name, address, TIN, and Medicare identification number of the managing organization must be provided. In addition, the applicant must furnish the date when the organization began managing the individual's business. If the applicant fails to provide contractors with any of this information, contact the applicant to request additional information; see §14.1.

Any name reported in this section must be checked against *Qualifier.net* (which contains MED and GSA Debarment data). If the managing organization is excluded or debarred, deny the application according to §14.3. In addition, check the name against the FID (if applicable) and

HIPDB. If the name is reported on the FID or HIPDB, follow procedures in §16.1 and 16.2 respectively.

C-D. Additional Organizations with Managing Control

The practitioner may use Sections 5C-5D to provide information on other managing organizations that meet the definition.

Section 5: Ownership and Managing Control Information (Organizations) - Form CMS-855B

Before reviewing the specific instructions for each Particular data element in this section, we recommend that you read the following explanation of the terms "Ownership" and "Managing Organizations."

Ownership and/or Managing Organizations

All organizations that have any of the following must be listed in Section 5B:

- 5 percent or more ownership (direct or indirect) of the enrolling supplier,
- Managing control of the enrolling supplier, or
- A Partnership interest in the supplier, regardless of the percentage of ownership the Partner has.

NOTE: All Partners within a Partnership must be reported on the application. This applies to general and limited Partnerships. For instance, if a limited Partnership has several limited Partners and each of them only has a 1 percent interest in the entity, each limited Partner would have to be listed on the application, even though each owns less than 5 percent. The 5 percent ownership threshold primarily applies to corporations and other organizations that are not Partnerships.

Owning/Managing organizations are generally one of the following types:

- Corporations (including limited liability corporations and non-profit corporations);
- Partnerships/limited Partnerships (as indicated above);
- *Limited Liability Companies*
- Charitable and Religious Organizations;
- Governmental/Tribal Organizations.

NOTE: With the exception of government entities, any entity listed in Section 2B1 and 2B2

of this application need not be listed in this section. For instance, suppose "Jones Ambulance Company" is set up as a corporation, with five stockholders each owning 20 percent. Assume further that Jones Ambulance Company is listed in Section 2B1 as the legal business name of the company.

Under this scenario, Jones Ambulance Company would not have to be listed in Section 5 because Jones is mentioned in Section 2B1 as the applicant. In other words, Jones is the applicant, not an owner or managing organization. Thus, only the stockholders need to be reported as owners in Section 5 and/or 6 (depending on whether the stockholders are individuals or organizations.)

However, government entities must be listed in Section 5, even if they are already listed in Section 2.

5 PERCENT OR MORE OWNERSHIP

All entities that own 5 percent or more of the enrolling supplier must be listed on the form. Many enrolling suppliers are owned by only one organization. For instance, if the *enrolling supplier listed in Section 2B1 is* an ambulance company that is wholly (100 percent) owned by Company A, the supplier would have to list Company A in section *5* since the latter owns at least 5 percent of the supplier.

In this case, (Company A) is considered to be a direct owner of the supplier *(the ambulance company/corporation* in that it actually owns the assets of the business.

There are occasionally more complex ownership situations, however. Many organizations that directly own an enrolling supplier are themselves wholly or partly owned by other organizations (or even individuals). This is often the result of the use of holding companies and parent/subsidiary relationships. Such organizations and individuals are considered to be "indirect" owners of the enrolling supplier. Using our example in the previous paragraph, if Company B owned 100 percent of Company A, Company B would be 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 (e.g., owns stock in the business), whereas an indirect owner has an ownership interest in an organization that owns the supplier. For purposes of enrollment, direct and indirect owners must be listed if they own at least 5 percent of the supplier. The Form CMS-855B Instructions contain an example of how suppliers can and should determine who needs to be listed as an owner on the application form.

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

(1) 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 supplier, and

(2) The interest is equal to or exceeds 5 percent of the total property and assets of the supplier. Refer to Example 2 of the Form CMS-855B Instructions for more information.

MANAGING CONTROL (ORGANIZATIONS)

Any organization that exercises operational or managerial control over the supplier, or conducts the day-to-day operations of the supplier, is a managing organization and must be listed. The organization need not have an ownership interest in the enrolling supplier in order to qualify as a managing organization. The organization could be a management services organization under contract with the supplier to furnish management services for one of the supplier's business locations.

Special Types of Organizations and Situations

Governmental/Tribal Organizations--If a Federal, State, county, city or other level of government, or an Indian tribe, will be legally and financially responsible for Medicare payments received (including any potential overpayments), the name of that government or Indian tribe should be listed as an owner. The enrolling supplier must submit a letter on the letterhead of the responsible government (e.g., government agency) or tribal organization, which attests that the government or tribal organization will be legally and financially responsible in the event that there is any outstanding debt owed to CMS. This letter must be signed by *the* "authorized official" of the government or tribal organization who has the authority to legally and financially bind the government or tribal organization to the laws, regulations, and program instructions of Medicare. See § 3.15 of this manual for further information on "authorized officials."

Charitable and Religious Organizations--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 this section. 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 (not just board members, directors, and/or managers) in Section 5 or Section 6 of the application. However, the contractor does not have to obtain the documentation, if as a result of the Qualifier.net review, they can determine that the enrolling entity is a non-profit charitable or religious organization.)

Ownership Transfer to a Family Member--If a sanctioned or excluded provider/supplier transfers its ownership interest to a family member, refer the case to BI. After its review, it must consult with the OIG to determine if the applicant/enrollee must be enrolled or terminated. If the OIG does not respond within 10 calendar days, any additional delay shall not count against the contractor for processing time purposes. However, this must be annotated in the file showing proof that OIG has the case.

A. Check Box

This box must be checked if there are no organizations with at least a 5 percent direct or indirect ownership interest in, Partnership interest in, and/or managing control over the enrolling supplier. If this box is not checked, the supplier must furnish information on those entities that own, manage, or have a Partnership interest in the supplier.

B. Organization with Ownership and/or Managing Control--Identification Information

Check to see whether the supplier is adding, deleting, or changing information on an existing organization. If one of these boxes is checked, make sure that an effective date is listed. If so, verify the requested change. If not, continue processing the application and then request additional information concerning the effective date. Remember that organizations with a 5 percent or greater ownership interest in, any Partnership interest in, or managing control over the supplier must be listed in Section 5. No individuals should be listed in this section.

1. The applicant must check whether it is providing information concerning 5 percent ownership, Partnership interest(s) and/or managing control. In addition, the applicant must provide the effective date of such ownership or control. If the organization listed has a Partnership interest in the supplier, the supplier must furnish the effective date of ownership.

2. The legal business name~~,~~ and the effective date of control must be listed.

3. The "Doing Business As" name and tax identification number of the organization(s) listed in this section must be provided. If no "Doing Business As" name is reported, assume that the entity does not have a DBA name.

4. If a Medicare identification number is shown, verify that it is accurate. Anytime contractors discover a discrepancy in this information, request additional information; see §14.1.

C. Adverse Legal History

1. For each organization listed in this section~~,~~ (other than organizations with only managing control, as these organizations are not required to complete this section), contractors must check the name and TIN or Medicare/Medicaid numbers against Qualifier.net (which contains MED and GSA data), and HIPDB. The organization must be checked against the database(s) regardless of whether the enrolling supplier states in this section that the organization has never had an adverse legal action imposed against it. If the organization is excluded or debarred, deny the application and explain the reason(s) for denial; see §14.3, Denial 1. If the applicant indicates that it has had an adverse legal action imposed against it but Qualifier.net does not report this, contact the OIG and/or Benefit Integrity/PSC to determine whether this can and should form the basis of an exclusion. Hold the application until the OIG decides whether the adverse legal action should result in an exclusion. If the OIG imposes an exclusion, deny the application. If not, contractors may continue to process the application normally. If the applicant is found on the Fraud Investigation Database, follow procedures as listed in §16.1.

If the applicant appears in the HIPDB, process the application according to §16.2.

2.If the applicant indicates that the organization that owns it has had an adverse legal action imposed against it, make sure that the applicant provides information concerning the type and date of the action, and what court(s) and law enforcement authorities were involved. Also, documentation that evidences the imposition/notification and resolution of the adverse action

must be submitted (e.g., notification of disciplinary action, criminal court documents). If the organization was excluded but has since been reinstated, verify this through the OIG and ask the applicant to submit written proof (e.g., reinstatement letter) indicating that such reinstatement has in fact taken place.

3.6 - Ownership and Managing Control Information (Individuals) – (Rev. 41, 05-23-03)

Section 6: Managing Employee Information - Form CMS-855I

The individual practitioner must furnish information about any and all managing employees. For purposes of this section, a managing employee is defined as any individual, including a general manager, business manager, office manager or administrator, who exercises operational or managerial control over the applicant's business/practice, or who conducts the day-to-day operations of the business/practice. For Medicare enrollment purposes, a managing employee also includes any individual who is not an actual employee but who, either under contract or through some other arrangement, manages the day-to-day operations of the practice/business.

NOTE: No information on ownership should be reported in this section.

All managing employees at any of the applicant's practice locations listed in Section 4B must be reported. However, individuals who (1) are employed by hospitals, health care facilities, or other organizations shown in Section 4B (e.g., the CEO of a hospital listed in Section 4B) or (2) are managing employees of any group/organization to which the practitioner will be reassigning his/her benefits, should not be reported.

A. Check Box

This box should be checked if there are no managing employees. If the applicant fails to check the box and no managing employees are listed, contact the applicant to request additional information; see §14.1.

B. Identifying Information

Check to see whether the applicant is adding, deleting, or changing information on an existing managing employee. If one of these boxes is checked, make sure that an effective date *for the change* is listed. *If the boxes for effective date of Ownership or Effective Date of Control have not or cannot be completed, the application can be processed without further discussion with the applicant.*

The name, Social Security Number (SSN), date of birth, and Medicare identification number of the employee must be provided. §1124(a)(1) and §1124A(a)(3) of the Social Security Act requires that the supplier furnishes the individual's SSN. If the applicant fails to provide this information, deny the application; see §14.3, Denial 6.

The practitioner should also indicate whether the managing employee is actually employed by him/her (e.g., W-2 employee). It is within the carrier's discretion to obtain a copy of the W-2 to verify employment. The contractor may request a copy of a pay stub, or any other validation source that shows employment in situations that are suspect.

C. Adverse Legal History

See Section 5B for *general* instructions concerning this section. *Note that Section 6C would only need to be completed by actual W2 employees of the supplier. Those managing employees that have a contractual relationship with the supplier must, of course, be reported in Section 6B, but would not need to furnish data in Section 6C.*

D-E. Identifying Information

This is to allow the applicant to identify more than one managing employee.

Section 6: Ownership and/or Managing Control Information (Individuals) - Form CMS-855B

Before proceeding with the instructions for Section 6, you may wish to review the explanation of the term "ownership" listed in Section 5. Although the explanation there refers to the applicant as the "enrolling supplier," the definitions and explanations for ownership have the same applicability to individuals.

For purposes of this application, the terms "officer," "director," and "managing employee" are defined as follows:

- Officer--any person whose position is listed as being that of an officer in the supplier's "Articles of Incorporation" or "Corporate Bylaws," OR anyone who is appointed by the board of directors as an officer in accordance with the supplier's corporate bylaws.
- Director--a member of the supplier's "Board of Directors." It does not include a person who may have the word "Director" in his/her job title (e.g., Departmental Director, Director of Operations). Note, however, that a person who has the word "Director" in his/her job title may be a "managing employee," as defined below. Moreover, where a supplier has a governing body that does not use the term "Board of Directors," the members of that governing body will still be considered "Directors." Thus, if the supplier has a governing body titled "Board of Trustees" (as opposed to "Board of Directors"), the individual trustees are considered "Directors" for Medicare enrollment purposes.
- Managing Employee--Any individual, including a general manager, business manager, or administrator, who exercises operational or managerial control over the supplier, or who conducts the day-to-day operations of the supplier. For purposes *of this section*, "managing employee" also includes individuals who are not actual employees of the supplier but who, either under contract or through some other arrangement, manage the day-to-day operations of the supplier.

The following individuals must be reported in §6A:

- All persons with 5 percent or more ownership (direct or indirect) of the enrolling supplier,

- If (and only if) the supplier is a corporation (whether for-profit or non-profit), all officers and directors of the supplier,
- All managing employees of the supplier, and
- All individuals with a Partnership interest in the supplier, regardless of the percentage of ownership the Partner has.

NOTE: All Partners within a Partnership must be reported on the application. This applies to general and limited Partnerships. For instance, if a limited Partnership has several limited Partners and each of them only has a 1 percent interest in the entity, each limited Partner would have to be listed on the application, even though each owns less than 5 percent. The 5 percent ownership threshold primarily applies to corporations and other organizations that are not Partnerships.

Contractors must use Qualifier.net to identify individuals who may have this type of relationship with the applicant. If during a managing employee's search, a name appears that was not listed on the application, query that name against Qualifier.net (for MED/GSA data), the FID (if applicable), and the HIPDB. If the contractor finds that this person was excluded or debarred, deny the application; see §14.3, Denial 1. If this person is on the FID or HIPDB, process according to §16.1 and §16.2, respectively. If contractors find a name that was otherwise not reported, request additional information.

A. Individual with Ownership and/or Managing Control-Identification Information

Check to see whether the applicant is adding, deleting, or changing information on an individual in this section. *If the boxes for effective date of Ownership or Effective Date of Control have not or cannot be completed, the application can be processed without further discussion with the applicant.*
Remember that individuals must be listed here in Section 6. No organizations should be listed in this section. If the applicant fails to check the box and there are no managing individuals listed, contact the applicant to request additional information; see §14.1.

Note that there must be at least one managing employee listed in this section.

1. The name, SSN, date of birth, and Medicare identification number of the individual must be provided. *§*1124(a)(1) and *§*1124A(a)(3) of the Social Security Act require that the supplier furnish us with the individual's SSN. If the applicant fails to provide the contractor with this information, deny the application; see §14.3, Denial 6. Should the supplier list an owning/managing individual in 6A1, it must also complete either 6A2, or 6A3 and 6A4. If the applicant fails to indicate in these sections which organization the individual is associated with, and what role that person has in the organization, verify this data with the applicant.

2. If the individual listed in Section 6A is directly associated with the enrolling supplier, the supplier should indicate this in this section.

3. If the individual listed in Section 6A is directly associated with an organization listed in Section 5B (e.g., the owning/managing organization), the legal business name of that organization the individual is associated with should be listed.

4. If the applicant lists the legal business name of the owning/managing organization in Section 6A3, it should also indicate in 6A4 the relationship that individual has with that organization.

B. Adverse Legal History

1. For each individual listed in this section, check the name and SSN or Medicare/Medicaid numbers against *Qualifier.net* (which contains MED and GSA data), and HIPDB. The individual must be checked against the aforementioned database(s) regardless of whether the enrolling supplier states in this section that the individual has never had an adverse legal action imposed against him/her. If the individual is excluded or debarred, deny the application and explain the reason(s) for denial; see §14.3, Denial 1. If the applicant indicates that the individual has had an adverse legal action imposed against it but Qualifier.net does not report this, contact the OIG and/or Benefit Integrity/PSC to determine whether this can and should form the basis of an exclusion. Hold (but continue processing) the application until the OIG decides whether the adverse legal action should result in an exclusion. If the OIG imposes an exclusion, deny the application. If not, continue processing the application.
If the individual appears on the FID, process the application according to §16.1. If the individual appears in the HIPDB, process the application according to §16.2.

2. If the applicant indicates that the individual has had an adverse legal action imposed against him/her, make sure that the applicant provides information concerning the type and date of the action, and what court(s) and law enforcement authorities were involved. Also, documentation that evidences the imposition/notification and resolution of the adverse action must be submitted (e.g., notification of disciplinary action, criminal court documents). If the *individual* was excluded but has since been reinstated, verify this through the OIG and ask the applicant to submit written proof (e.g., reinstatement letter) indicating that such reinstatement has in fact taken place.

3.7 - Chain Home Office Information - (Rev. 41, 05-23-03)

Section 7: Chain Home Office Information

This Section does not apply to Individuals and Suppliers.

3.8 - Billing Agency – (Rev. 29, 07-26-02)

Section 8: Billing Agency - Form CMS-855I and Form CMS-855B

A. Check Box

Determine if the applicant does not use a billing agent. If "yes", continue to B. If "no" continue to next section. If the applicant fails to check the box, request additional information; see §14.1.

B. Billing Agency Name and Address

1. Indicate the business name and tax identification number of the billing agency. Query this name against Qualifier.net, FID (IF APPLICABLE) and HIPDB databases. If a match is found, refer this application to Benefit Integrity/PSC.

2. List the "Doing Business Name" if applicable.

3. The business street address is mandatory; fax and email addresses are not.

C. Billing Agreement/Contract Information

Check to see whether the applicant is changing information in this section. If checked, make sure that an effective date is listed. If so, enter this data into the system. If not, continue processing the application and request the effective date.

If the applicant indicates that he/she is using a billing agency, the applicant must answer all the questions concerning his/her agreement. If contractors wish to verify/validate information contractors may request a copy of the billing agency agreement. Although it is not necessary to review all billing agreements, contractors should occasionally request copies of the agreements; for example, a large group practice for which contractors have reviewed an agreement in the initial enrollment phase could be asked again to provide an agreement when adding new physicians to an existing group. The agreement must meet the requirements in MCM §3060. In cases where violations are discovered, the supplier must be notified that it is in violation of the laws governing assignment of claims. In the case of a new supplier applicant, inform the applicant that the billing arrangement violates Medicare policy regarding assignment and that the applicant will not receive assignment privileges unless the arrangement is modified to conform to Medicare assignment rules. (See regulations at 42 CFR 424.82.) If the applicant returns the application without changing the billing arrangement, the appropriate action is to enroll the applicant (assuming everything is correct) and deny assignment privileges to the supplier.

The following outcomes should be applied consistent to the answer. Anytime contractors find the answers do not correspond, contact the applicant by telephone to discuss the findings. Do not contact the billing agent to discuss. If the contractor cannot reach the applicant by telephone, contractors can send a letter explaining the requirements found in 3060.

1. If the applicant indicates that he/she does not have unrestricted access to its Medicare remittance notice, contact the applicant to inform him/her of his/her responsibilities for the bills submitted in his/her name.

2. If the applicant indicates that Medicare payment is going directly to him/her, verify that this corresponds with the pay-to-address on the Form CMS-855. If the pay-to-address is a post office box, verify with the applicant that he/she has ownership of the post office box. If payment is

going directly to the bank, verify that the account is only in the name of the applicant and meets Part 3 MCM 3060.11. If contractors find that the above is not true, request the applicant to answer question 3 "No" and to answer questions 4, 5, and 6 appropriately. Inform the applicant that he/she must abide by requirements in PART 3 MCM 3060.

3. If the applicant indicates that Medicare payment is going directly to the bank, verify that this corresponds with the pay-to-address on the Form CMS-855. Make sure that he/she answered questions to a), b), and c) as yes. If contractors find that the applicant is incorrect, request the applicant to answer question "No" and to answer questions 5 and 6 appropriately and inform the applicant that he/she must abide by requirements in PART 3 MCM 3060. If the applicant indicates, "No" go to question 5.

4. If Medicare payment is going directly to the billing agent, make sure that the applicant answers questions in 5. If the billing agent cashes the check, make sure that the applicant indicates "Yes" for the 5 conditions, which are met in accordance with PART 3 MCM 3060.10. If the applicant responds "No" the billing agency does not cash the check, make sure that he/she responds to 5b. If in 5b he/she checks "No" request the billing agreement to determine where payment is going. If the applicant answers "No" that Medicare payment does not go to the billing agent, verify that the applicant answers question 6.

5. Verify that the information submitted corresponds to the information in the pay-to-address. If it does not, follow-up with the applicant with their pay-to-address information.

In reviewing the answer to the questions, if contractors find any inconsistencies or any reason to believe that the information is not correct, request a copy of the billing agreement. This is at the contractor's discretion and is not negotiable with the applicant. Contractors do not have to have specific information to justify the request of a billing agreement. This request is solely the contractor's decision based on its review of this Form CMS-855 or any other group affiliation that is associated with this enrollment.

If an applicant does not correct its billing agreement, notify the applicant this his/her billing arrangement violates Medicare policy. If the applicant fails to come into compliance, follow the instructions on revoking physician assignment privileges as outlined in Carrier Manual, Part 3 §3060.13.

As soon as contractors find that an enrolled physician has entered into or continued a prohibited payment arrangement after being advised that the arrangement is improper, or failed to cooperate in furnishing the information necessary to resolve the issue, notify and forward a copy of the file to the RO. The RO considers whether further development of the facts or admonition of the physician will be useful before taking steps to revoke the physician's assignment privileges. If the CMS RO finds that a physician's right to receive assigned benefits is to be revoked, it follows the procedure summarized in Carrier Manual, Part 3 §14025.

As soon as an improper billing arrangement is corrected, the revocation of assignment privileges should be rescinded. In situations where an improper billing arrangement needs to be corrected, use the following language in all correspondence with the supplier:

SITUATION: For an applicant who chooses not to Participate and whose enrollment application is being returned because his/her billing arrangement violates the regulations regarding payment to an agent, use the following language:

Dear (Name of Health Care Supplier):

Your application to enroll in the Medicare program is being returned for further action. After review of your agreement with (Name of Billing Company), we have determined that it is not in compliance with Federal regulations regarding payment to an agent as specified in 42 CFR 424.80. Medicare will not make payment to an agent if the agent's compensation is based on the amounts billed or collected or is dependent upon the actual collection of Medicare payment.

You need to decide whether you wish to enroll in Medicare with or without assignment privileges. If you wish to secure assignment privileges, your agreement with (Name of Billing Company) must be amended to comply with 42 CFR 424.80. If you fail to comply with these requirements, you may enroll in Medicare, but you will not be given assignment privileges. Please call if you have any questions regarding this determination at (Phone number of Enrollment Specialist)."

SITUATION: For an applicant who returns his or her enrollment application with a billing arrangement that continues to violate the regulations regarding payment to an agent and who has not filed a Participation agreement, use the following language to deny the applicant assignment privileges (assuming that all other enrollment criteria are met):

Dear (Name of Health Care Supplier):

Your application to enroll in Medicare has been approved; however, you will not be allowed assignment privileges. As we informed you in our letter of (date of first letter), your agreement with (Name of Billing Company) is not in compliance with Federal regulations regarding payment to an agent as specified in 42 CFR 424.80. Medicare will not make payment to an agent if the agent's compensation is based on the amounts billed or collected or is dependent upon the actual collection of Medicare payment. If you modify your agreement so as to comply with these requirements, you may be given assignment privileges. If you feel that this determination was made in error, you may appeal this decision. Any such appeal must be filed with this office within 60 days of the date of this letter. Please call (Name of Enrollment Specialist) at (Phone number of Enrollment Specialist) between the hours of 9:00 a.m. - 4:00 p.m. if you have any questions regarding this determination.

SITUATION: For an applicant who chooses to Participate and whose enrollment application is being returned because his/her billing arrangement violates the regulations regarding payment to an agent, use the following language:

Dear (Name of Health Care Supplier),

Your application to enroll in the Medicare program is being returned to you for further action. After reviewing your agreement with (Name of Billing Company), we have determined that it is not in compliance with Federal regulations regarding payment to an agent as specified in 42 CFR 424.80. Medicare will not make payment to an agent if the agent's compensation is based on the amounts billed or collected or is dependent upon the actual collection of Medicare payment.

In your application, you elected to be a Participating physician and to take advantage of all of the benefits of Participation. Your Participation agreement cannot take effect until you comply with the CFR provisions. If you fail to comply with these requirements, you may enroll in Medicare but you will not be given assignment privileges and your Participation agreement cannot take effect. Please call if you have any questions regarding this determination. Please advise us if you have modified your billing agent agreement to comply with Medicare assignment rules and furnish us with a copy of the amended agreement.

SITUATION: For an applicant who returns his or her enrollment application with a billing arrangement that continues to violate the regulations regarding payment to an agent and who has filed a Participation agreement, use the following language to deny them assignment privileges (assuming that all other enrollment criteria are met):

Dear (Name of Health Care Supplier),

Your application for enrollment in Medicare has been approved; however, you will not be allowed assignment privileges. As we informed you in our letter of (Date of First Letter), your agreement with (Name of Billing Company) is not in compliance with Federal regulations provisions regarding payment to an agent as specified in 42 CFR 424.80. Medicare will not make payment to an agent if the agent's compensation is based on the amounts billed or collected or is dependent upon the actual collection of Medicare payment. In your application, you elected to be a Participating physician and to take advantage of all of the benefits of Participation. However, your Participation agreement cannot take effect until you comply with the above cited regulatory provisions. As soon as you demonstrate compliance with these requirements, your assignment privileges will be restored and your Participation agreement will take effect. If you feel that this determination was made in error, you may appeal this decision. Any such appeal must be filed with this office in writing within 60 days of the date of this letter. Please call if you have any questions regarding this determination.

SITUATION: If you find an enrolled entity in violation of the regulations regarding payment to an agent, use the following language to inform them of the violation and the required corrective action:

Dear (Name of Health Care Supplier),

It has come to our attention that your contractual arrangement with (Name of Billing Company)is not in compliance with Federal regulations regarding payment to an agent as specified in 42 CFR 424.80. Medicare will not make payment to an agent if the agent's compensation is based on the amounts billed or collected or is dependent upon the actual collection of Medicare payment.

You must reply in writing within 15 days from the date of this letter indicating whether you intend to comply with the above cited regulation, and, if so, include with your reply an amended contract with your billing agent that fully complies with such regulation. If you fail to comply with these requirements, your assignment privileges will be revoked. If you feel that this determination was made in error, you may appeal this decision. Any such appeal must be filed with this office in writing within 60 days of the date of this letter. Please call if you have any questions regarding this determination.

SITUATION: For health care suppliers who maintain agreements that violate the regulations for more than 15 days after initial notification of the violation, and for whom the RO has approved revocation of assignment privileges, use the following language to revoke their assignment privileges.

Dear (Name of Health Care Supplier)

Your assignment privileges have been revoked effective 15 days from the date of this letter. As we informed you in our letter of (Date of First Letter), your agreement with (Name of Billing Company) is not in compliance with the Federal regulations regarding payment to an agent as specified in 42 CFR 424.80. Medicare will not make payment to an agent if the agent's compensation is based on the amounts billed or collected or is dependent upon the actual collection of Medicare payment

If in the future you comply with these requirements, your assignment privileges will be restored. If you feel that this determination was made in error, you may appeal this decision. Any such appeal must be filed with this office in writing within 60 days of the date of this letter. Please call if you have any questions regarding this determination.

SITUATION: For health care suppliers who must accept assignment but whose billing arrangements violate the regulations regarding payment to an agent, use the following language:

Dear (Name of Health Care Supplier):

Your application for enrollment in Medicare is returned for your action. After reviewing your agreement with (Name of Billing Company), we have determined that it is not in compliance with the Federal regulations regarding payment to an agent as specified in 42 CFR 424.80. Medicare will not make payment to an agent if the agent's compensation is based on the amounts billed or collected or is dependent upon the actual collection of Medicare payment.

Because you fail to comply with these requirements, you cannot enroll in the Medicare program since your supplier specialty requires you to take assignment. However, if you comply with the above requirements, you can enroll in the Medicare program. If you wish to complete your application to enroll in Medicare, amend agreement with (Name of Billing Company) to comply with the above cited regulation. Please call (Name of Enrollment Specialist) at (Phone number of Enrollment Specialist) between the hours of 9:00 a.m. - 4:00 p.m. if you have any questions regarding this determination.

SITUATION: For health care suppliers who must accept assignment who return their enrollment application with a billing arrangement that continues to violate the regulations regarding payment to an agent, please use the following language:

Dear (Name of Health Care Supplier):

Your application for enrollment in Medicare has been denied. As we informed you in our letter of (date of first letter), you agreement with (Name of Billing Company) is not in compliance with Federal regulations regarding payment to an agent specified in 42 CFR 424.80. Medicare will not make payment to an agent if the agent's compensation is based on the amounts billed or collected or is dependent upon the actual collection of Medicare payment.

Since your supplier specialty requires that you accept assignment for the services that you bill to Medicare, we cannot enroll you until your billing agreement comes into compliance. If in the future you comply with these requirements, you can reapply to enroll in the Medicare program. If you feel that this determination was made in error, you may appeal this decision. Any such appeal must be in writing and filed with this office within 60 days of this letter. Please call (Name of Enrollment Specialist) at (Phone number of Enrollment Specialist) between the hours of 9:00 a.m. - 4:00 p.m. if you have any questions regarding this determination. If a group has previously filed a contractual agreement with the carriers, it is not necessary to request a billing agreement from every group member.

3.9 - Electronic Claims Submission Information – (Rev. 29, 07-26-02)

Section 9: Electronic Claims Submission Information - Form CMS-855I and Form CMS-855B

If the applicant indicates that he/she intends to file claims electronically, the applicant must submit a copy of his/her current EDI agreement with this application. If, however, an EDI agreement is submitted after enrollment, the provider enrollment unit does not have to complete or maintain this information.

A. Check Box

Continue to process the application if this box is checked. If none of the boxes are checked, and this information is blank, assume that this section does not apply.

B. Check Box

If this box is checked, provide the applicant information on how to submit his/her claims electronically.

C. 1st Clearinghouse Name and Address

1. Legal Business Name and Tax identification Number - If the entity does not disclose its TIN, it can use its submitter number. If any of the information is missing or incomplete, do not request additional information. Continue to process the application.

2. Annotate the "DBA" name.

3. List the street address of the entity in the system.

D-E. These sections allow the applicant the ability to report on more than one clearinghouse.

3.10 - Staffing Company – (Rev. 29, 07-26-02)

Section 10: Staffing Company - Form CMS-855I and Form CMS-855B

This section is to capture information if an individual is employed by, or is under contract to render medical services with a company that staffs health care organizations (e.g., hospital emergency rooms) to render medical services.

A. Check Box

Determine if the applicant has checked the box as required. If the box is blank, request additional information.

B. 1st Staffing Company using this Supplier - Name and Address

If the applicant is contracted or employed by a staffing company, the applicant must provide a name and address of who is using his/her services. Check the legal business name of this entity against Qualifier.net, FID (IF APPLICABLE), and HIPDB databases.

C. 1st Staffing Company using this supplier - Contract/Agreement Information

The applicant must respond to these questions. If blank, request additional information.

1. If the applicant responds yes to this question, this may affect the payment to agent rules. See §3060.10 for further clarification.

2. If applicant indicates that the contracts supersedes/contradicts the agreement, request both contracts for further investigation. If the contractor finds discrepancies within both contracts, contact the RO for further guidance. If the applicant indicates "No", and the contractor wishes to verify or validate this response, request copies of both contracts. Again, if a discrepancy is found, contact the RO.

D-E. 2nd Staffing Company using this supplier - Name and Address

This space is provided to accommodate for any additional staffing companies used. Follow instructions as above.

3.11 - Surety Bond Information - (Rev. 29, 07-26-02)

This Section does not apply to individuals and suppliers

3.12 - Capitalization Requirements for Home Health Agencies – (Rev. 29, 07-26-02)

This Section does not apply to individuals and suppliers

3.13 - Contact Person – (Rev. 29, 07-26-02)

Section 13: Contact Person - Form CMS-855I and Form CMS-855B

This is the person contractors call if there are any questions regarding the information furnished in the application. If the applicant does not provide a contact person, call the individual who signed the application for any questions that need clarification. If the contractor needs to request additional information, request it from the contact person.

3.14 - Penalties for Falsifying Information on This Enrollment Application – (Rev. 29, 07-26-02)

Section 14: Penalties for Falsifying Information on This Enrollment Application - Form CMS-855I and Form CMS-855B

This section lists various criminal and civil penalties that can be imposed against a Medicare supplier (or an applicant for enrollment in the Medicare program) for fraudulent/abuse activity. Contractors should familiarize itself with this section, as doing so will enhance their ability to spot potential fraud or abuse.

3.15 - Certification Statement – (Rev. 41, 05-23-03)

Section 15: Certification Statement

Individual

An individual practitioner is the only person who may sign the Form CMS-855I. This applies not only to initial enrollment but also to any changes and/or updates to *Form* CMS-855 data already on file. Individual practitioners may not delegate the authority to sign the Form CMS-855I on their behalf to any other person.

Supplier

A. Additional Requirements for Medicare Enrollment

The Certification Statement contains certain requirements that must be met in order for the supplier to be enrolled in the Medicare program.

By their signature(s), the authorized official and delegated official(s) bind the supplier to all of the requirements listed in the Certification Statement and acknowledge that the supplier may be denied entry to or revoked from the Medicare program if any requirements are not met or maintained.

B. Authorized Official Signature

For initial enrollment the Certification Statement must be signed and dated by the authorized official of the supplier. An authorized official is defined as an appointed official to whom the supplier has granted the legal authority to enroll it in the Medicare program, to make changes and/or updates to the supplier's status in the Medicare program (e.g., new practice locations, change of address), and to commit the supplier to fully abide by the laws, regulations, and program instructions of Medicare.
The authorized official must be the supplier's general Partner, chairman of the board, chief financial officer, chief executive officer, or president, or must hold a position of similar status and authority within the organization. The authorized official can also be a person who is a direct owner of 5 percent or more of the enrolling supplier (see Section 5 for definition of a direct owner). The organization can only have one authorized official at any given time. In addition to meeting the requirements listed in this paragraph, the authorized official must be listed in Section 6.

If contractors are fairly certain that the authorized official signing the application has the authority to bind the organization (e.g., signatory is a CEO, president, or - if the applicant is a governmental entity – head of the County Health Department), *the contractor* may continue processing the application. Should contractors have doubts about the authorized official's authority, contact the authorized official or the applicant's contact person to obtain more information about the official's job title and/or authority to bind. If the contractor remains unconvinced about the official's authority to bind the applicant, request that someone else within the organization (e.g., CFO, chairman of the board) sign the application. If the supplier refuses, deny the application.

*In accordance with section 25 of these instructions, d*ocument any contact made with the authorized official, contact person, or other supplier official when investigating whether the authorized official has the power to bind.

Only the authorized official has the authority to sign the initial Form CMS-855 application on behalf of the supplier. The delegated official has no such authority.

The signature of the authorized official must be original. Faxed, stamped, or photocopied signatures cannot be accepted. Check whether the supplier is changing the authorized official currently on file and make sure that an effective date is listed. In order to change authorized officials, the supplier must:

1. Check the "Delete" box in Section 15B and provide the effective date of the deletion. In addition, the authorized official being deleted must provide his or her printed name, signature, and date of signature. *Since the file should already have that official's job title, SSN, date of birth, and Medicare identification number,* he/she need not supply this information again. If the deleted authorized official failed to provide his/her signature, contact the provider to find out why. If contractors become convinced that obtaining this signature would pose an undue burden on the supplier (e.g., the deleted authorized official was terminated or has left the company), you may forgo the signature requirement. The contractor should, however, remind the supplier over the telephone that the deleted authorized official no longer has the authority to sign the Form CMS-855A on behalf of the supplier. Document that this reminder was given as well as the reason(s) why the signature of the deleted authorized official was unattainable.

2. Submit a copy of the page containing the Certification Statement, check the "Add" box in Section 15B and provide the effective date of the addition. Also, the new authorized official must provide the information requested in 15B, along with his/her signature and date of signature. When changing authorized officials, the new authorized official assumes from the prior authorized official all of the powers (e.g., the power to delegate authority to a delegated official) previously held by the latter, and also agrees to adhere to all of the requirements (including those outlined in Section 15B) listed in the Certification Statement. However, a change in authorized officials has no bearing on the authority of existing delegated officials to make changes and/or updates to the supplier's status in the Medicare program. If the supplier is submitting a change of information (e.g., new practice location, change of address, new Part-owner) and the authorized official signing the form is different from the official you currently have on file, secure the signature of the latter person or the signature of a delegated official already on file. If the supplier wants or needs a new authorized official, it must follow the procedures outlined above. If the supplier is changing information about an existing authorized official (e.g., change in job title), it must check the "Change" box and provide the effective date, along with the changed data. The authorized official must then sign and date the form.

3.16 - Delegated Official – (Rev. 41, 05-23-03)

If the new authorized official is not currently listed in the contractor's records and is not disclosed in Section 6, request that the new official complete Section 6.

Section 16. Delegated Official (Optional) - Form CMS-855B

A delegated official is either: (1) a *W2* managing employee of the provider, or (2) holds a 5 percent direct ownership interest, or any Partnership interest in the provider. This individual must have been delegated the legal authority by the authorized official listed in Section 15B to make changes and/or updates to the provider's status in the Medicare program, and to commit the provider to fully abide by the laws, regulations, and program instructions of Medicare.

For purposes of Section 16 only, the term "managing employee" means any individual, including a general manager, business manager, or administrator, who exercises operational or managerial control over the supplier, or who conducts the day-to-day operations of the supplier. This does

not include persons who, either under contract or through some other arrangement, manage the day-to-day operations of the supplier but who are not actual *W2* employees. For instance, suppose Joe Smith is hired as an independent contractor by the supplier to run its day-to-day-operations. Under the definition of "managing employee" for Section 6 (Ownership and Managing Control (Individuals)), Smith would have to be listed. However, under the Section 16 definition (as described above), Smith cannot be a delegated official because he is not an actual W-2 employee of the supplier. Independent contractors are not considered "managing employees" under Section 16.

In addition to meeting the requirements listed in this paragraph, the delegated official must be reported in section 6.

A. Check Box

If the supplier chooses not to appoint a delegated official, it should check the box in this section. There is no requirement that the supplier have a delegated official. Should no delegated officials be listed, however, the authorized official remains the only individual who can make changes and/or updates to the supplier's status in the Medicare program.

B. Delegated Official Signature

1. If the supplier chooses to add a delegated official OR to delete an existing one, the delegated official being added must provide all of the information requested in this section, including his/her signature and date thereof. If the delegated official is being deleted, he/she need only provide his/her name. A signature is not required. In both cases, the authorized official currently on record must provide his/her signature and date in Section 15B and 16B2. The signature of the authorized official in Section 16B2 constitutes a legal delegation of authority to any and all delegated official(s) listed in §16.

If the delegated official is a W-2 employee, he or she should check the appropriate box in 16B1. If this box is not checked and it does not appear that the delegated official is a Partner or a 5% *direct* owner (e.g., the delegated official is not listed in Section 6), the contractor should verify the capacity in which this individual is acting as a delegated official.

Only the authorized official has the authority to sign the initial Form CMS-855 application on behalf of the supplier. The delegated official has no such authority. However, once a delegated official has been designated, he/she may make any changes and/or updates to the supplier's status in the Medicare program.

When making changes and/or updates to the supplier's enrollment status, the delegated official should sign Section 15B. However, *if* the delegated official signs Section 16B1 instead, accept the signature and continue processing the application.

The authorized official, nevertheless, still retains the authority to make changes to the Form CMS-855, if he/she chooses to do so.

If the supplier is changing a delegated official, it must:

*C*heck the "Delete" box and provide the effective date of the deletion. Only the deleted delegated official's name need be provided. A signature of the delegated official is not necessary. Since contractors should already have that official's job title, SSN, date of birth, and Medicare identification number on file, he/she need not supply this information again. Submit a copy of the page containing Section 16, check the "Add" box and provide the effective date of the addition. The new delegated official must complete this section in full. In addition, the authorized official currently on record must provide his/her signature and date in Section 15B and 16B2. If the supplier is changing information about an existing delegated official (e.g., change in job title), it must check the "Change" box and provide the effective date, along with the changed data. The authorized official must then sign and date the form in Section 15B. (Section 16B2 need not be completed.) *If the new delegated official is not currently listed in the contractor's records and is not disclosed in Section 6, request that Section 6 be completed for the new individual.*

If the supplier is submitting a general change of information (e.g., new practice location, change of address, new Part-owner, etc.) and the delegated official listed on the change is different from the official(s) *on file, send a copy of the application (but only those pages that were completed as part of the change request) along with a blank certification statement to the supplier for the proper signature.* If the supplier wants a new delegated official, it must follow the procedures outlined above. A supplier can have no more than three delegated officials at any given time.

The changes and/or updates that may be made by the delegated official include situations where the supplier is contacted by the contractor in order to clarify or obtain information needed to continue processing the supplier's initial or revalidating Form CMS-855 application. Delegated officials may not delegate their authority to any other individual. Only an authorized official may delegate the authority to make changes and/or updates to the supplier's Medicare status.

3.17 - Attachments – (Rev. 29, 07-26-02)

Section 17. Attachments to the General Application

- Check licensure requirements to ensure that appropriate licenses have been included. (Except for certified suppliers, i.e. ASCs and Portable X-Ray license after recommendation).

- Verify all information as presented with the state agency that issues licenses or certifications

- Verify that the information presented on Form CMS-855 is the same as on the license or certificate.

4 - Ambulance Service Suppliers - Attachment 1 - (Rev. 41, 05-23-03)

4.1 - State License Information – (Rev. 41, 05-23-03)

1. State License Information

A. Geographic Service Area

Check whether the supplier is adding or deleting information concerning the service area. If so, make sure that an effective date is listed.

1. The applicant must list the geographic area(s) in which it provides services. If the supplier indicates that it provides services in more than one carrier's jurisdiction, it must submit a separate Form CMS-855B for each carrier.

2. If the applicant checks that it is deleting an area in which it had provided services, it must specifically identify this area in A2.

B. State License Information

Check whether the applicant is adding, deleting, or changing information pertaining to its licensing data. If so, an effective date must be listed.

The applicant must indicate whether it is licensed in the state where services are rendered.

If the applicant is licensed, it must provide license information. Verify that the applicant submits all applicable licenses or certificates. If a Particular county that the applicant provides services in requires the applicant to be licensed or certified in that jurisdiction, make sure that the applicant submits copies of these documents. If the applicant does not complete the "License Number," "Issuing State," "Issuing County/Parish," "Effective Date," or "Expiration Date" boxes, yet this information is on the license/certification, there is no need to request additional information.

NOTE: Air Ambulance - Practice Location

An air ambulance supplier that is enrolling in a state to which it flies in order to pick up patients (that is, a state other than where its base of operations is located) is not required to have a practice location or place of business in that state. So long as the air ambulance supplier meets all other criteria for enrollment in the Medicare program, the carrier in that state may not deny the supplier's enrollment application solely on the grounds that the supplier does not have a practice location in that State.
This policy, however, applies only to air ambulance suppliers, and is inapplicable to all other suppliers and providers. In addition, contractors may deny the application for a reason other than the lack of a practice location. For instance, if the air ambulance supplier's owner was excluded from the Medicare program, contractors can deny the application irrespective of whether the supplier has a practice location in that State. The contractor is only prohibited from denying an

air ambulance supplier's application on the sole basis that the supplier does not have a practice location in that State.

4.2 - Description of Vehicle – (Rev. 41, 05-23-03)

2. Description of Vehicle

A. 1st Vehicle Information

Check whether the applicant is adding, deleting, or changing information pertaining to its licensing
data. If so, an effective date must be listed.

1. Information identifying the type of vehicle (automobile, aircraft, boat, etc.) year, make, model, and vehicle identification number must be submitted for each vehicle. The applicant must also submit a copy of its registration for each vehicle.

2. The applicant's vehicles must meet all Federal, State, and local requirements. Concerning Federal standards, 42 CFR §410.41 requires that the vehicle be specifically designed and equipped for transporting the sick or injured, and possess the equipment listed in this section. If the vehicle does not meet the requirements of §410.41 (and applicable state and local requirements), the applicant cannot bill for services rendered by this vehicle. If this vehicle is the only one listed by the applicant, therefore, deny the application because the supplier has no vehicle that meets regulatory requirements. If the applicant lists other vehicles, review to ensure that they meet all Federal, State, and local standards. If at least one of them does, the applicant can qualify as an ambulance supplier, but cannot bill for services rendered by the other vehicle(s) that do not meet the required standards.

3. The applicant must identify the services provided by this vehicle, the specific type of vehicle, and the number of crewmembers that will accompany each vehicle on runs. The latter figure must comply with the requirements of 42 CFR 410.41. If the ambulance supplier cannot prove that its equipment meets the conditions described in 42 CFR 410.41 (e.g., vehicle contains customary patient care equipment including, but not limited to, a stretcher, clean linens, first aid supplies and oxygen equipment), continue to process the application but inform the applicant clarification is needed. If any information is incomplete, continue the application verification process and request additional information. (Follow procedures in Section 14.) The applicant must provide evidence of recertification on an ongoing basis for registered vehicles. In addition, the vehicle(s) must also have safety and lifesaving equipment as required by state and local authorities. For Advance Life Support (ALS) vehicles, the applicant must provide contractors with a list of the required equipment as well as written documentation of its certificate from the authorized licensing and regulation agency for which the applicant is eligible to operate.

NOTE: If the vehicle is an air ambulance, the applicant must provide the following items:

- A written statement signed by the President, Chief Executive Officer, or Chief Operating Officer that gives the name and address of the facility where the aircraft is hangared; and

- Proof that the air ambulance supplier or its leasing company possesses a valid charter flight license (FAA Part 135 Certificate) for the aircraft being used as an air ambulance. If the air medical transportation company owns the aircraft, the owner's name on the FAA Part 135 certificate must be the same as the supplier's name on the enrollment application. If the air medical transportation company leases the aircraft from another entity, a copy of the lease agreement must accompany the enrollment application. The name of the company leasing the aircraft from that other entity must be the same as the supplier's name on the enrollment application.

2nd Vehicle Information

This section is to capture information about a 2nd vehicle, if needed. Follow the same instructions as above.

4.3 - Qualification of Crew – (Rev. 41, 05-23-03)

3. Qualification of Crew

Check whether the applicant is adding, deleting, or changing information pertaining to a crewmember. If so, an effective date must be listed.

1. Information identifying each crewmember must be submitted.

2. The applicant must list the training completed by each crewmember and attach copies of all/any certificates verifying such training. If the crewmember does not meet Federal, State, and local training requirements, the applicant cannot bill for services furnished by the crewmember. Contractors must check each crewmember's name and SSN against *Qualifier.net, FID (IF APPLICABLE) and HIPDB databases. If the crewmember is excluded/debarred* deny the application and explain the reason(s) for denial. (See §14.3, Denial 1). If the applicant appears on the FID (IF APPLICABLE) or HIPDB, process the application according to §16.1 and 16.2, respectively.

NOTE: Crewmembers need not submit recertification documentation unless specifically requested to do so by the carrier. (i.e., on an "as needed" basis).

4.4 - Certified Basic Life Support - (Rev. 41, 05-23-03)

Section 4: Certified Basic Life Support (BLS)

A. Check Box

If the applicant checks this box, proceed to Section 5 (Certified Advanced Life Support (ALS)). If the box is not checked, the applicant must answer 4B.

B. Paramedic Intercept Services Information

Check whether the applicant is changing information that was previously reported. If such a change is being made, make sure that an effective date is provided. Paramedic Intercept Services involve 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. (See 42 CFR §410.40 for more information.) If the applicant indicates that it has such an arrangement with an ALS ambulance supplier, the applicant must attach a copy of the ~~as~~signed contract(s).

4.5 - Certified Advanced Life Support - (Rev. 41, 05-23-03)

Section 5: Certified Advanced Life Support (ALS)

A. Check Box

If the applicant checks this box, proceed to Section 6 (Medical Director Information). If the box is not checked, the applicant must answer the questions in 5B.

B. Certified Advanced Life Support Questionnaire

Check whether the applicant is changing information that was previously reported. If such a change is being made, make sure that an effective date is provided.

1. The applicant should check whether it is certified to perform defibrillation. If yes, a copy of defibrillation certification must be attached.

2. Paramedic Intercept Services involve 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. (See 42 CFR §410.40 for more information). If the applicant indicates that it has such an arrangement with an BLS ambulance supplier, the applicant must attach a copy of the signed contract(s).

4.6 - Medical Director Information – (Rev. 41, 05-23-03)

Section 6: Medical Director Information

A. Check Box

If the applicant is not required to have a Medical Director in the state in which it is applying, it should check this box.

B. Medical Director Information

If the box in 6A is not checked, the applicant must furnish information about its Medical Director. The medical director must also be reported in Section 6.

5 - Independent Diagnostic Testing Facilities (IDTFs) - Attachment 2 – (Rev. 41, 05-23-03)

The carrier shall determine that all IDTF applicants meet the IDTF standards as elaborated in 42 C.F.R. Section 410.33 titled, "Independent Diagnostic Testing Facility," prior to enrollment and granting an IDTF billing number. The determination, which shall be placed in the applicant's file, shall be based upon review of the following: (1) the applicant's entire Form CMS-855, including the Attachment 2 data specific to IDTFs; (2) the results of the mandatory site visit; and (3) any additional, relevant documentation obtained by the carrier.

NOTE: Pathology tests and Clinical Lab (CLIA) tests are not to be considered as diagnostic tests for purposes of determining if an entity needs to be enrolled as an IDTF.

An IDTF applicant must pass all relevant verification and documentation requirements as any other supplier applicant. Therefore, the carrier shall thoroughly review all Parts of their Form CMS-855 in accordance with the basic guidance concerning review of other supplier applicants. Many IDTFs are mobile units and/or have more than one practice location. They must properly complete Section 4, Practice Location.

5.1 - Entities That Must Enroll as (IDTFs) - (Rev. 41, 05-23-03)

The carrier may be asked by a potential applicant if it is required to enroll as an IDTF. This is a relevant question since many enrollees can perform and bill for diagnostic tests on the physician fee schedule without enrolling as an IDTF. Basically, an applicant that is considered to be a physician's office or a Part of a hospital can bill for the diagnostic tests and not be enrolled as an IDTF. An applicant that is independent of a physician office or hospital must enroll as an IDTF. The following paragraphs provide guidance regarding the types of entities that may or may not be sufficiently independent from a physician office or hospital to require enrollment as an IDTF.

An entity generally should not be considered independent from a physician office or hospital if it has the following characteristics:

- It is a physician practice that is owned, directly or indirectly, by one or more physicians or by a hospital;
- The entity primarily bills for physician services (e.g., evaluation and management (E & M) codes) and not for diagnostic tests;
- It furnishes diagnostic tests primarily to patients whose medical conditions are being treated or managed on an ongoing basis by one or more physicians in the practice;
- The diagnostic tests are performed and interpreted at the same location where the practice physicians also treat patients for their medical conditions.

However, if a substantial portion of the entity's business involves the performance of diagnostic tests, the diagnostic testing services may be a sufficiently separate business to warrant enrollment as an IDTF *(it is considered independent for purposes of enrollment).* In that case, the physician or group can continue to be enrolled as a physician or a group practice of physicians, but must also enroll as an IDTF. The physician or group can bill for professional fees and the diagnostic tests they perform on their patients using their billing number. However, the practice must bill as an IDTF for diagnostic tests furnished to Medicare beneficiaries who are not patients of the practice. *The carrier should advise the entity how to bill for physician office tests versus IDTF tests and advise the claims personnel of the dual enrollment.*

We recognize that many diagnostic tests are radiological procedures that require the professional services of a radiologist. We also recognize that the nature of a radiologist's practice is generally very different from those of other physicians because radiologists usually do not bill E & M codes or treat a patient's medical condition on an ongoing basis. Nevertheless, a radiologist or a group of radiologists should not necessarily be required to enroll as an IDTF. The following features would
indicate that a radiology practice is not "independent from a physician office or hospital":

- The practice is owned by radiologists, a hospital, or both;

- The owner radiologists and any employed or contracted radiologists regularly perform physician services (e.g., test interpretations) at the location where the diagnostic tests are performed;

- The billing patterns of the enrolled entity indicate that the entity is not primarily a testing facility and that it was organized to provide the professional services of radiologists (e.g., the enrolled entity should not bill for a significant number of purchased interpretations, it should rarely bill only for the technical component of a diagnostic test, and it should bill for a substantial percentage of all of the interpretations of the diagnostic tests performed by the practice); and

- A substantial majority of the radiological interpretations are performed at the practice location where the diagnostic tests are performed.

The carrier shall ask the potential applicant any relevant questions to substantiate that the applicant meets the above criteria.

Hospitals - To be exempt from the IDTF standards and enrollment as an IDTF, because the applicant is a Part of a hospital, the applicant should be provider-based in accordance with Section 404 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, Pub. L. No. 106-554. Diagnostic tests billed by the hospital to their own patients, which are performed under arrangement, do not require IDTF billings and therefore do not require IDTF enrollment. However, if the entity providing the under arrangement diagnostic tests, performs diagnostic tests which it will bill under its own billing number (not the hospital's), then said entity is subject to the IDTF rules. Therefore, the entity may or may not require enrollment as an IDTF for its own patients, subject to the guidance provided in this manual section.

For enrollment purposes an entity can be enrolled as an IDTF (they are considered independent) if they require IDTF enrollment as stated above. This is the case even if there is joint ownership with the hospital, or they are located on the hospital campus, or they cannot qualify as provider-based. When enrolling the IDTF advise the entity how to bill for IDTF tests versus hospital tests (including under arrangement tests). Advise the claims personnel of the dual enrollment and contact the cognizant fiscal intermediary (FI) of the arrangement.

Ambulatory Surgical Centers (ASCs) - An ASC cannot bill for separate diagnostic tests they perform during the ASC's scheduled hours of operation (see 42 CFR 416.2). If an entity, which owns an ASC, performs diagnostic tests in the same physical facility as the ASC, but during a time period when the ASC is not in operation, those diagnostic tests can be billed by an enrolled IDTF. Therefore, in that instance an additional separate enrollment by the entity as an IDTF is required.

Suppliers of Mobile X-ray Services - A mobile IDTF that provides X-ray services is not classified as a portable X-ray supplier. Therefore, it cannot bill for transportation (R0070) and setup (Q0092). If it desires to bill for these services, it must also enroll and qualify as a portable X-ray supplier and bill as a portable X-ray supplier in accordance with the portable X-ray supplier billing rules. The carrier shall assure that an entity which is enrolled as an IDTF and a portable x-ray supplier is not double billing.

5.2 - Review of Attachment 2, Independent Diagnostic Testing Facility (IDTFs) – (Rev. 41, 05-23-03)

1. Service Performance

A - Standards Qualifications

The applicant must complete this item. If they have not, contact the applicant for additional information. An IDTF applicant can back bill (the same as any other supplier) from the date that they actually met all the supplier qualifications for their supplier type. Therefore, if an applicant is determined to have met the IDTF requirements and is granted a billing number, it can back bill from the date where they can provide reasonable evidence that they met the IDTF requirements. An example would be where the applicant is granted an IDTF number in July 1, 2000, but had the same acceptable, 1) properly calibrated equipment, 2) qualified technician(s), and 3) qualified supervisory physician(s), as of May 1, 2000. That applicant can back bill for services on or after May 1, 2000 for IDTF services based upon evidence, such as payroll records, personnel records, contracts, equipment purchase records, etc., that they met the standards as of May 1, 2000. The carrier, when necessary, shall request confirming documents from the applicant or review such documents as Part of the site visit. The applicable personnel and equipment do not have to be the same as those provided as of July 1, 2000. However, use of the same personnel and equipment will facilitate this process. The carrier shall document the file with the method used for determining when the applicant is entitled to bill for services. An applicant who has purchased the assets of an existing IDTF is not automatically allowed to continue billing. It must apply as a new IDTF and may back bill once enrolled. Use of the same personnel and equipment as the

previously enrolled IDTF can facilitate the determination that the new IDTF can bill as of the date of the sale.

B - CPT-4 and HCPCS Codes

The applicant must complete this section. The codes listed should reflect all procedure codes which the applicant will perform and bill as an IDTF. If an applicant does not list what contractors consider to be relevant codes then make a request for additional information.

The applicant must list all equipment it will use to perform the listed tests. The carrier shall determine if the equipment list provided is adequate for the tests which the applicant will perform. If the equipment list is considered incomplete, then make a request for and review additional information.

The carrier shall confirm that the equipment is properly calibrated and maintained by requesting and reviewing any relevant documents or other evidence on the matter. This information can be obtained before, during or after a site visit. The carrier shall document the method and result of the calibration and maintenance confirmation.

If an enrolled IDTF desires to perform additional CPT or HCPCS code tests not originally specified on its CMS-855B, which are for procedure types and supervision levels similar to its previously allowed codes, the carrier shall follow the following procedures. Have the IDTF amend its CMS-855B to add the additional codes and equipment listing. A new site visit is not required. However, if an enrolled IDTF will now be performing CPT codes for different types of procedures, or with different supervision levels, then a new site visit is required. Examples are as follows: a) If a sleep laboratory is adding CPT codes for MRIs, a site visit is required, and b) If an existing imaging center is doing MRIs for knees starts doing MRIs for shoulders, a new site visit is not required.

For new applicants the carrier shall use carrier edits to restrict the IDTF billings to the CPT and HCPCS codes listed on the CMS-855B, which have been reviewed by the carrier. The use of carrier edits shall apply to all IDTFs that are not already enrolled as of the effective date of this change. The IDTFs, which have already been enrolled, previously do not require updated carrier edits. Carriers are strongly encouraged to (but are not required to) enter carrier edits for existing enrolled IDTFs as time and resource constraints permit. However, if an enrolled IDTF is performing additional CPT codes, the carrier shall enter carrier edits for all codes previously disclosed and the new ones cited.

2. Interpreting Physician Information

The applicant shall list all physicians whose diagnostic test interpretations it will bill. This includes physicians who are providing purchased interpretations (*which shall be in accordance with the MCM, §3060.5)* to the IDTF as well as physicians who are reassigning their benefits to the IDTF. The carrier shall review and document that all physicians listed are Medicare enrolled. The carrier shall review that all interpreting physicians who are reassigning their benefits to the IDTF have the right to do so. The carrier shall review and document that any reassignment of benefits forms required have been submitted. The carrier shall also review and document that the

interpreting physician(s) listed are qualified to interpret the types of tests (codes) listed. Sometimes it may be necessary for the carrier to contact another carrier to obtain required information. The carrier should document the file if it has obtained the required information from another carrier. If the applicant does not list any interpreting physicians, do not request additional information because the applicant may not be billing for the interpretations (the physicians may be billing for themselves). However, the applicant cannot bill globally for interpreting physicians not listed.

3. Non-Physician Personnel (Technicians) who Perform Tests

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

A. If the non-physician person is state licensed or certified, the applicable license and/or certification should be attached and reviewed by the carrier. A notarized or certified true copy can be accepted with no further checks. A non-notarized or non-certified true copy should be checked with the applicable licensing authority. Not all states have licensing requirements for all diagnostic tests. In those instances, checking "No" in block 2 is acceptable. The carrier is responsible for knowing and ascertaining if there are specific state licensing requirements for the tests, which the technician will perform. The carrier shall maintain documentation to substantiate this.

B. If the technician is certified by a national credentialing body then the applicable certification should be attached and reviewed by the carrier. A notarized or certified true copy can be accepted with no further checks. A non-notarized or non-certified true copy should be checked with the applicable credentialing authority. The carrier shall decide which organization(s) constitute a national credentialing body for the tests the technician will perform. *However, if the credentialing body is not one that is generally recognized as acceptable for the tests being performed, then the carrier should refer the issue to the IDTF Carrier Medical Director (CMD) workgroup for their opinion. The carrier's own CMD should facilitate this action.*

All technicians must meet the standard of a state license or certification, or national credentialing body. The only exception to this is when a Medicare payable diagnostic test is not subject to state license or certification of the technician performing the test, and no generally accepted national credentialing body exists. In that instance, the technician should be listed and the IDTF should submit as an attachment any educational/credentialing and/or experience that the person has and fully justify why the individual should be considered qualified to perform the test(s) cited. The carrier shall use its judgment as to whether the technician is qualified to perform the diagnostic tests the IDTF is performing.

The IDTF technicians do not have to be employees of the IDTF. They can be contracted by the IDTF. The carrier shall document how it determined that the technicians listed met the licensing or credentialing requirements. All enrolling IDTFs must meet the technician licensing or credentialing requirements at the time of their enrollment. Carriers may no longer grant temporary exemptions from licensing and certification requirements.

Hospital Employment - This block should be completed with a yes or no. The technician can be employed by both an IDTF and a hospital (or other entity, including a physician practice), but he or she cannot be scheduled to perform services for both entities at the same time. If the technician is employed by a hospital, the carrier should notify the FI who is assigned to the hospital, so that the FI can confirm that the hospital is properly allocating the appropriate portion of all direct and indirect costs associated with the technician. A technician who is employed by a hospital or physician's office does not automatically qualify as being properly credentialed to perform services for an IDTF.

4. Supervisory Physician(s)

According to 42 CFR 410.33 (b)(1) an IDTF must have one or more supervising physicians who are responsible for the direct and ongoing oversight of the quality of the testing performed, the proper operation and calibration of equipment used to perform tests, and the qualifications of nonphysician IDTF personnel who use the equipment. Not every supervising physician has to be responsible for all of these functions. One supervising physician could be responsible for operation and calibration of equipment, while other physicians are responsible for test supervision and the qualifications of nonphysician personnel. The basic requirement is that all the supervisory physician functions be properly met at each location, regardless of the number of physicians involved. This is particularly applicable to mobile IDTF units which are allowed to use different supervisory physicians at differing locations. They may have a different physician supervise the test at each location. The physicians used have to meet only the proficiency standards for the tests they are supervising. The carrier shall use its discretion to determine if the supervisory physician(s) meet the proficiency standards stated in 42 CFR 410.33(b)(2). Supervisory physicians do not have to be employees of the IDTF. They can be contracted physicians for each location serviced by an IDTF.

A - Supervisory Physician Information

1. Supervising Physician Information - This block must be completed by furnishing all the required identifying information about all supervisory physicians. The carrier shall check and document that each supervisory physician is licensed to practice in the State(s) where the diagnostic tests he or she supervises will be performed and that the physician is Medicare enrolled. The physician(s) does not have to be Medicare enrolled in the state where the IDTF is enrolled. The carrier shall verify the licensing of each supervisory physician enrolled with another carrier based upon the physician's license submission and discussions with the carrier where they are enrolled. A physician group practice cannot be considered a supervisory physician. Each physician of the group who actually performs an IDTF supervisory function must be listed. If a supervisory physician has been recently added or changed, the updated information is required to be reported via Form CMS-855 *as a Change* of Information. However, the new supervisory physician is required to have met all the supervisory physician requirements at the time any tests were performed. The carrier shall review the new physician(s) using the procedures in this manual section. *If a supervisory physician is listed, whom the carrier knows has been listed with several IDTFs, then the carrier should check with the physician to determine that the physician is still acting as supervisory physician for the previously enrolled IDTFs. If the*

carrier is aware that a supervisory physician is listed as a supervisory physician for more than 5 IDTFs, then the carrier should refer the matter to their benefit integrity unit for further investigation.

2. General Supervision (For Overall IDTF Operation) - In accordance with 42 CFR 410.33(b), all IDTFs must have one or more supervisory physicians who are responsible for the direct and ongoing oversight of the quality of the testing performed, the proper operation and calibration of the equipment used to perform tests, and the qualification of non-physician personnel who use the equipment. In applying this definition we cannot impose a physical distance limit between where the test is performed and where the supervisory physician is located. If the carrier question(s) whether a remote supervisory physician is actually performing this general supervision function, it should ask for specific written procedures or other documentation which the IDTF may have in place. Although, specific written procedures are not specifically required, a satisfactory written response to carrier questions is.

All the check boxes in block 2 must be checked. However, they can be checked through use of more than one physician. The carrier shall review that all three general supervision requirements have been checked.

3. Type of Supervision Provided in Accordance with 42 CFR 410.32(b)(3) - According to 42 CFR 410.33(b)(2), in the case of a procedure requiring the direct or personal supervision of a physician as set forth in 42 CFR 410.32(b)(3), the IDTF's supervisory physician must furnish this level of supervision. The carrier enrollment reviewer shall be familiar with the definitions of personal, direct and general supervision set forth at 42 CFR 410.32(b)(3). The carrier shall document that all reviewers of IDTF applications are familiar with said regulation section.

The carrier shall check and document that the applicant has checked the *highest required* level of supervision for the tests being performed. *At least one supervisory physician must check a box in item 4A3 of Attachment 2 of Form CMS-855B, at the highest supervision level required for the tests to be performed.*

B - Attestation Statement for Supervising Physician

1. Acknowledgement of Codes Supervised - This statement must be completed and signed by all supervisory physicians listed.

2. Disclosure of Codes Not Supervised - This block may not need to be completed. If it is not completed it is assumed that the supervisory physician(s) listed supervise for all codes listed. If this block is filled in, then the carrier must ensure that all codes listed in 1B are covered through the use of multiple supervisory physicians.

3. Physician Signature - The carrier shall check the signature against the signature of the enrolled physician. This should be documented. If the physician is enrolled at a different carrier, contractors should call the applicable carrier and obtain the listed telephone number of the physician. Call the listed telephone number to determine that the physician acknowledges that he or she has signed the attestation statement. In all cases the carrier shall contact the supervisory

physician(s) by telephone or as Part of the required site visit. In Particular, the carrier should ascertain and document that each supervisory physician listed actually exists (i.e. a phony or inactive physician number is not being used) and that the physician is aware of his or her responsibilities. For general supervision of IDTF operations, these responsibilities are outlined in 42 CFR 410.33.

5.3 - Enrollment Checks – (Rev. 41, 05-23-03)

All new IDTF applications should receive a thorough desk review, (including telephone contacts as necessary) and a mandatory site review. Both reviews should be coordinated so that the site reviewer can ask for and/or obtain additional information that could not be developed through a desk review. These reviews must be accomplished prior to IDTF enrollment and receipt of a billing number. *The carrier may interview the owner of the IDTF based upon carrier discretion.* We are no longer issuing billing numbers subject to later reviews and/or site visits. The purpose of both reviews is to determine that:

1. The IDTF actually exists;

2. One or more proficient supervisory physicians who furnish the required level of supervision actually exist and understand their responsibilities;

3. All technicians are properly credentialed and aware of who is the supervisory physician and how to get in contact with him or her; and

4. Properly maintained and calibrated equipment for performance of the listed tests is being utilized.

The end result of the review should be a written documented determination citing the results of the review. This determination should be for an approval, denial or a return for additional information. The determination should cite the review steps taken, any problems encountered, and establish the date from which services can be billed by the IDTF.

Site Reviews

All IDTFs must receive a site visit prior to enrollment. The site visit should normally be accomplished within the 60 day processing time. If the contractor is required to visit a remote location, *needs to perform follow-up visits, or has difficulty in scheduling reviews of patients requiring direct or personal supervision, an extension in processing time should be requested. The RO will review this on a case-by-case basis. Contact the RO provider enrollment contact to determine if they will* grant an extension. If yes, document the decision.

The purpose of a site visit is to verify that an IDTF actually exists at the location shown on Form *CMS-855,* and that the information shown on ATTACHMENT 2 of the Form *CMS-855* is correct, verifiable, and in accordance with IDTF regulatory and manual requirements. To the maximum extent practical, site visits should be performed on an unannounced basis. This may not always be practical for IDTFs that are located a great distance from the site reviewer or are mobile units.

Additional follow-up site visits may be required based upon carrier judgment. The site visit may be performed by qualified individuals who are employees of either the carrier or an individual or organization with which the carrier has contracted for the performance of this function. Individuals performing site visits are not required to have any specific medical training or licenses. However, the carrier shall provide any training as required to ensure that the site visitor is familiar with the equipment to be verified, and the qualifications of the technicians and supervisory physician(s). The site visitor should do the following:

1. Verify that the location address shown on Form *CMS-855* is the actual address for the IDTF;

2. Verify that any required test equipment shown listed in ATTACHMENT 2 actually exists and is present at the IDTF;

3. *Be present at the facility to confirm* that for diagnostic tests being performed at the IDTF, a state licensed or certified technician listed in ATTACHMENT 2, is actually performing the test;

4. For tests that require personal supervision, *be present at the facility to confirm* that a supervisory physician shown in block 3 of ATTACHMENT 2 is actually present and with the patient;

5. For tests that require direct supervision, *be present at the facility to confirm* that a supervisory physician shown in block 3 of ATTACHMENT 2 is within the required proximity of the patient; and

6. For tests that require general supervision:

- Ask the technician the name of the supervisory physician(s) who are supervising the tests. That physician should be listed in ATTACHMENT 2.

- Ask the technician how he or she can get in contact with the supervising physician(s) and confirm the technician's knowledge of procedures to follow if he or she has a problem with performing the diagnostic tests.

- Ask for a copy of any procedures related to how the general supervision requirement is being met. However, written procedures are not specifically required and they can be furnished separate from the site visit. If no written procedures exist a satisfactory written response to carrier questions is required.

If a distant IDTF cannot readily be observed, on an unannounced basis performing services for which they will bill, then the carrier can request a patient schedule including the tests scheduled from the IDTF. The carrier can then make the site visit unannounced based upon the schedule.

If an IDTF has more than ten practice locations, but is not a mobile unit, the carrier does not have to perform a site visit to each location. A sampling of practice locations can be performed.

However, each practice location address must be verified via telephone contacts and the use of independent data validation sources.

Mobile units are required to list their geographic service area. They can be site visited by the following methods: (1) The mobile unit may visit the office of the site reviewer, or (2) The site reviewer can obtain an advance schedule of the locations the IDTF will be visiting and conduct the site visit at one of those locations. *Mobile units that are performing CPT or HCPCS code procedures which require direct or personal supervision require special attention. The carrier should discuss with the applicant and* ***all supervisory physicians*** *listed: a) How they will perform this type of supervision on a mobile basis, b) What their responsibilities are, and c) That a patient's physician performing direct or personal supervision for the IDTF on their patient should be aware of the prohibition concerning physician self-referral for testing (in particular this concerns potentially illegal compensation to the supervisory physician from the IDTF). The carrier should pay special attention to the required initial claims review plan when enrolling a mobile unit that requires direct or personal supervision. The carrier shall maintain a listing of all mobile IDTFs which perform procedure codes which require direct or personal supervision.*

An enrolled IDTF may make a request to perform additional CPT or HCPCS codes. All additional codes should be listed on a change of information to Form CMS-855B. If the additional codes indicate that the enrolled IDTF is performing procedures which are of a type and supervision level similar to those already disclosed, then a new site visit is not required. An example is when an IDTF which performs MRIs for shoulders starts performing MRIs for hips. The carrier should enter carrier edits for the new procedures and any previously disclosed CPT or HCPCS codes shown on previous Form CMS-855B.

If an enrolled IDTF desires to add additional procedures which are not similar to those previously disclosed and reviewed, then the carrier should perform a site visit for the additional procedures. An example is when an IDTF that enrolled listing sleep studies wants to add ultrasound tests or skeletal x-rays. All IDTF claims for the additional procedures should be suspended until the IDTF passes all enrollment requirements for the additional procedures, (i.e., supervisory physician, non-physician personnel (technicians and equipment). Suspended claims should be paid only when the IDTF presents evidence that all requirements for the new procedures were met when the tests were actually performed. This determination should be made in writing and placed in the enrollment file. When the IDTF has been reviewed and accepted for the additional procedures, then the carrier should enter carrier edits for the new procedures and any previously disclosed CPT or HCPCS codes shown on previous Form CMS-855B.

If the site reviewer notes any egregious conditions that may not be in accordance with any Federal or Medicare laws or regulations, they should report them to the appropriate authority. This includes compliance with disability access or general health and safety violations.

If an IDTF which listed only general supervision CPT codes and was reviewed for only general supervision tests, starts performing, *or makes a request via an amended Form CMS-855B to perform,* CPT code tests that require direct or personal supervision, promptly suspend all payment for other than the general supervision codes. *A review should* be made when the Form CMS-855B is amended to show the new codes, new supervisory physician certification and new equipment and technician certification, as applicable. A new site visit is required to confirm that

the IDTF is qualified to perform the CPT codes requiring a higher level of physician supervision. The results of the review should be documented in writing. The suspended claims can be paid only after the confirmation, including the site visit that the IDTF qualifies for the new supervision level tests. Suspended claims should be paid only when the IDTF presents evidence that all requirements for the new supervision level tests were met when the tests were actually performed. This determination should be made in writing and placed in the file. *When the IDTF has been reviewed and accepted for the additional codes requiring a higher level of supervision, then the carrier should enter carrier edits for the new procedures and any previously disclosed CPT or HCPCS codes shown on previous CMS-855Bs.*

If an enrolled IDTF, which is not a mobile or portable unit adds a practice location, any additional fixed practice locations must receive a site visit. The carrier shall also ascertain that the equipment at the new location is not the same equipment listed at the already enrolled location. An exception would occur if the IDTF added equipment to its enrolled location to compensate for the equipment transferred to the new location. These changes should require an updated Form CMS-855B with a practice location change with any applicable Attachment 2 changes.

5.4 - Special Considerations – (Rev. 41, 05-23-03)

A - Billing Issues

Nothing in this document or in the Provider/Supplier Enrollment Application shall be construed or interpreted to authorize billing by an IDTF, physician, physician group practice, or any other entity that would otherwise violate the physician self-referral prohibition set forth in §1877 of the Social Security Act and related regulations. Carriers must deny claims submitted in violation of §1877 and demand refunds of any payments that have been made in violation of §1877.

Consistent with 42 CFR 410.32(a), the supervisory physician for the IDTF, whether or not for a mobile unit, may not order tests to be performed by the IDTF, unless the supervisory physician is the patient's treating physician and is not otherwise prohibited from referring to the IDTF. The supervisory physician is the patient's treating physician if he or she furnishes a consultation or treats the patient for a specific medical problem and uses the test results in the management of the patient's medical problem.

If an IDTF wants to bill for an interpretation performed by an independent practitioner off the premises of the IDTF, the IDTF must meet the conditions shown in Part 3 MCM 3060.5 concerning purchased interpretations. In this case there is no reassignment of benefits, since the purchaser of the test is considered the supplier of the test. When the technical component of a test is performed by the IDTF and the interpreting practitioner is the practitioner who ordered the test, the IDTF cannot bill for the interpretation. The interpreting practitioner must bill the interpretation since the IDTF cannot bill the interpretation when the interpreting physician is the referring physician.

Additional services related to, or generally considered required for, performing a diagnostic test are payable to an IDTF if they are commonly separately reimbursed to a physician in a physician's office setting. *An IDTF can bill these practitioner services when they are performed*

by a qualified practitioner in accordance with the coverage, payment and general billing rules, and in accordance with the reassignment of benefit and purchased test rules. However, an IDTF is not allowed to bill for surgical procedures that are clearly not related to, or required for a diagnostic test. In some cases, an Ambulatory Surgical Center (ASC) may be performing the surgery. The ASC and the IDTF can be owned by a single entity but must have a separate enrollment and billing numbers for each.

B - Transtelephonic and Electronic Monitoring Services

Transtelephonic and electronic monitoring services (e.g. twenty four hour ambulatory EKG monitoring, pacemaker monitoring and cardiac event detection) may perform some of their services without actually seeing the patient. *Most but not all of these billing codes are 93733, 93736, 93226, 93232, 93271, 93225, 93231, 93230, 93224, 93014, 95956, 93012, 93731, 93236, 93233, 93040, 93270, 95953 and G0004 – G0008 and G0016.* These monitoring service entities should be classified as IDTFs and must meet all IDTF requirements. We currently do not have specific certification standards for their technicians; technician credentialing requirements for them are at carrier discretion. They do require a supervisory physician who performs General Supervision. Final enrollment of a transtelephonic or electronic monitoring service as an IDTF requires a site visit.

For any entity that lists and will bill code*s G0004 – G0008, G0015, G0016,* the carrier must make a written determination that the entity actually has a person available on a 24 hour basis to answer telephone inquiries. Use of an answering service in lieu of the actual person is not acceptable. *The person performing the attended monitoring should be listed in Section 3 of Attachment 2 of Form CMS-855B. The qualifications of the person are at the carrier's discretion.* The carrier shall check that the person is available by attempting to contact the applicant during non-standard business hours. In Particular, at least one of the contact calls should be made between midnight and 6:00 AM. If the applicant does not meet the availability standard they should receive a denial.

C - Slide Preparation Facilities and Radiation Therapy Centers

Slide Preparation Facilities and Radiation Therapy Centers are not IDTFs. Slide preparation facilities are entities that provide slide preparation services and other kinds of services that are payable through the technical component of the surgical pathology service. These entities do not provide the professional component of surgical pathology services or other kinds of laboratory tests. The services that they provide are recognized by carriers for payment, as codes in the surgical pathology code range (88300) to (88399) with a technical component value under the physician fee schedule. The services provided by these entities are usually ordered by and reviewed by a dermatologist. Slide preparation facilities generally only have one or two people performing this service.

All enrolled Slide Preparation Facilities should be enrolled under specialty code 75. Carriers shall convert any of these entities previously enrolled using the IDTF specialty code to the specialty code of 75.

Radiation Therapy Centers provide therapeutic services and therefore are not IDTFs. All enrolled Radiation Therapy Centers should be enrolled under specialty code 74. Carriers shall convert any of these entities previously enrolled using the IDTF specialty code to the specialty code of 74.

D - Transitioning From Another Supplier Type To IDTF Or To Add An IDTF Enrollment

The above guidance and the revision of the IDTF Attachment to the Form *CMS-855* clarify when an entity must enroll as and bill for the technical component of diagnostic tests as an IDTF. Based upon the above guidance and the form changes, some enrolled entities may require conversion to, or an additional, enrollment as, an IDTF. Some enrolled providers who are properly enrolled as another supplier type, may in the future need to enroll as an IDTF because of changes in their status regarding billings, ownership, or supervision practices. If the carrier believes that an enrollee requires an additional enrollment as an IDTF, or a change to an IDTF enrollment, it should advise the applicant and cite the reason why. Sometimes the applicant may voluntarily submit a rationale or documentation why the IDTF enrollment is not required. If the applicant is required to become an IDTF, the carrier shall expedite the required enrollment process. The carrier should not make changes in the enrollee's payment status during the time period when the applicant is attempting either to substantiate why it is not an IDTF, or to obtain enrollment as an IDTF. However, if the enrollee fails or refuses to obtain required IDTF status after attempts by the carrier to expedite the process, the carrier shall commence any required payment disallowances, enrollment denial, or terminations that may be necessary to rectify the situation.

E – Diagnostic Mammography

If an IDTF performs diagnostic mammography, they must have a Food and Drug Administration certification to perform the mammography. However, an entity that only performs diagnostic mammography should not be enrolled as an IDTF. They should be separately enrolled.

F – 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. They should be separately enrolled and advised to bill separately. The carrier should advise its claims unit to ensure that the CLIA codes are not being billed under the IDTF provider number.

G – Therapeutic Procedures

An IDTF shall not be allowed to bill for any CPT or HCPCS codes that are solely therapeutic.

H – Other Non-IDTF Providers

The carrier shall not enroll using specialty code 47 any new providers who are not clearly IDTFs, except for those entities whose enrollment is described in this section 5.4. Exceptions to this policy shall only be permitted when instructed by CMS. All other entities that do not meet a

specific specialty code type requirement should be enrolled as Other or Unknown or as instructed by CMS.

6 - This Section Has Been Intentionally Left Blank - (Rev. 7, 05-31-01)

7 - Reassignment of Benefits - Form CMS-855R – (Rev. 41, 05-23-03)

Form CMS-855R is to be completed for any individual who will reassign his/her benefits to an eligible entity. The form must be completed for the following situations:

a. An individual *practitioner is currently enrolled in Medicare and will reassign benefits to an entity that is currently enrolled;*

b. An individual has been reassigning benefits to an entity and is terminating the reassignment*; and*

c. An individual reporting a change in the type of income tax withholding.

If the individual supplier wants to reassign his or her benefits and has not been enrolled, the applicant must complete Form CMS-855I as well as Form CMS-855R. (Form CMS-855I and Form CMS-855R can be submitted concurrently.) The newly enrolling entity that is going to receive benefits must complete Form CMS-855B.

NOTE ABOUT REASSIGNMENT

It is important to remember that benefits can only be reassigned to a provider/supplier (hereinafter referred to as "supplier"), not to the practice location(s) of that supplier. For instance, suppose Dr. X works for Smith Medical Group (SMG), which is a corporation. SMG has six practice locations. Legally, Dr. X can only reassign his benefits to the group. He cannot reassign benefits to any of the six practice locations, since practice locations are ineligible to receive reassigned benefits. Using our example, assume further that Dr. X works at all six practice locations; consequently, the carrier gave him six different PINs, one for each location. Some may think that this results in six different reassignments, and that this would therefore exceed the five-reassignment threshold (discussed below). However, it really counts as only one reassignment, since there is only one supplier to which benefits are being reassigned.

With this in mind, carriers should not require each practitioner in a group to submit a Form CMS-855R each time the group adds a practice location. Suppose Smith Medical Group had three physicians - X, Y, and Z - and six practice locations. All three doctors have reassigned their benefits to SMG. Now, SMG wants to add a seventh practice location. X, Y, and Z do not have to submit Form CMS-855Rs for this seventh location because, as stated before, they do not reassign their benefits to practice locations - only to the supplier itself, which they have already done. Of course, if the group practice *as well as* X, Y, and Z are all enrolling for the first time, and the doctors want to reassign their benefits to the group, each doctor would list each of the

group's practice locations on his/her Form CMS-855R. But once they have reassigned their benefits to the group, the doctors need not submit Form CMS-855Rs each time the group adds a practice location. In situations that have large # of practitioners in a group, it is appropriate to request a list of those who will be joining the additional location as to avoid assigning new numbers to every physician.

Five or more Reassignments

Any time a Form CMS-855R is received that results in the physician reaching or exceeding 5 individual reassignments contact the physician to verify that all reassignments are still current and legitimate and to update the contractor's provider file and the UPIN. In requesting the applicant to declare all his/her reassignments, do not provide the number of reassignments currently shown on the provider file for that physician. Rather, ask the physician to declare the number of his/her current reassignment arrangements and attach Form CMS-855*I* to verify/validate the arrangement. *Inform the physician who has reached the 5 reassignments to provide the contractor with his/her SSN in Section 1A2, provide the group(s) or organization(s) to which he/she will reassign benefits in section 4A1, and sign the certification statement in Section 15 attesting that the information is true, correct, and complete on Form CMS-855I.* Once the completed Form CMS-855*I is received*, delete any reassignment on the provider file and the UPIN registry that were not declared. Prior to deleting the number, verify that the billing number is not currently showing billing activity. If it is, contact the physician to ask if the reassignment was overlooked. If the contractor suspects any suspicious activity, send that information to Benefit Integrity/PSC to investigate. Retain all documentation in the contractor's provider data files. If contractors discover that the physician has declared a reassignment that was not utilized within a 12-month period, deactivate the number and inform the physician. If a physician does not provide contractors with the Form CMS-855*I* within 30 days, contact the physician directly. If after 45 days the physician does not respond, contact the physician in writing informing him/her that any number affiliated with a group that has not *been* declared will be deactivated immediately. *Contractors must update its provider within 45 days from receiving the Form CMS-855I.*

If the contractor has previously contacted the physician to request that he/she declare his/her reassignments, it is not necessary to do so if he/she adds another reassignment. If however you have not received verification that all of his/her reassignments are still active, query the physician. Contractors can use the following language when contacting the physician concerning an individual who has five or more reassignments.

PURPOSE: Letter to Physicians Requesting Verification of Current Reassignment Arrangements.

Date:

Dear (Name of Physician)

Address of Physician (NOT BILLING AGENT)

As Part of our continuing efforts to guard against Medicare abuses, we want to ensure that we are making payments on your behalf to entities with which you are currently affiliated. Also we want

to make sure that the entities you have designed to receive payment are eligible under Law 18, Section 1861(r). In order to do this, we are requesting information as to who currently has authorization (an employer, facility, or health care delivery system) to receive reassigned payment on your behalf per Federal Regulations 42 CFR §424.80.

Attached is the *application for Individual Health Care Practitioners, Form CMS-855I that we are asking you to complete to acknowledge that the reassignments shown on our file are still current. Please complete the following sections for our review:*

- *Your SSN in Section 1A2;*
- *The name of the group(s) or organization(s) to which you reassign benefits in Section 4A1; and*
- *Sign the certification statement in Section 15 attesting that the information is true, correct and complete on Form CMS-855I.*

Any entity who is not identified will automatically be canceled as ineligible to receive Medicare payments on your behalf. We are asking for a response within 30 days of receipt of this letter. If you are unable to provide us with the information in that time frame, please contact us immediately. If you have any questions regarding this letter, please contact (Name of Enrollment Specialist) at (Phone number of Enrollment Specialist) between the hours of 9:00 a.m. - 4:00 p.m.

PURPOSE: Letter to Physician to Inform them that Group Numbers will be Deactivated if not Declared

Date:

Dear (Name of Physician)

Address of Physician (NOT BILLING AGENT)

We sent you a letter dated (date of letter), requesting that you validate the current payment arrangements. This information is extremely important so that we can safeguard against abuses to the Medicare program. Please take a moment to complete and acknowledge that under the terms of your employment or contract, you are reassigning your benefits to an authorized entity. Attached is the *application for Individual Health Care Practitioners, Form CMS-855I that we are asking you to complete to acknowledge that the reassignments shown on our file are still current. Please complete the following sections for our review:*

- *Your SSN in Section 1A2;*
- *The name of the group(s) or organization(s) to which you reassign benefits in Section 4A1; and*

- *Sign the certification statement in Section 15 attesting that the information is true, correct and complete on Form CMS-855I.*

If we do not hear from you within 15 days of receipt of this letter we will need to take immediate action to disassociate any provider number on file that is receiving Medicare payment on your behalf. After such action, you will only be eligible to receive Medicare payment under your own Medicare provider number. If you are unable to provide this information within 15 days or need assistance, please contact (Name of Enrollment Specialist) at (Phone number of Enrollment Specialist) between the hours of 9:00 a.m. - 4:00 p.m.

7.1 - Individual Reassignment of Medicare Benefits – (Rev. 29, 07-26-02)

1. General Application Information - Form CMS-855R

Reason for Submittal of this Application

Check Box

The applicant must provide the reason it is completing the Form CMS-855R.

7.2 - Supplier Identification – (Rev. 29, 07-26-02)

2. Supplier Identification

The applicant must provide the legal business name and Medicare identification number of the supplier to which Medicare benefits are being reassigned. This is the name the supplier uses to report to the IRS.

7.3 - Individual Practitioner Identification – (Rev. 29, 07-26-02)

3. Individual Practitioner Identification

Each member who is reassigning or terminating reassignment of his or her benefits to the entity listed above must complete this section.

For individuals who receive Form 1099, all services must be provided in the group setting. The group must disclose for each individual who will bill under the group number the IRS withholding method. If a member indicates that he or she receives the IRS Form-1099 at the end of the calendar year, the applicant can reassign his or her benefits to the group if he or she meets the requirements in MCM §3060 or MIM §3488. For those individual practitioners who show W-2 and the contractor wants to validate this information, request a copy of a pay stub, or any other validation source that shows employment. The contractor may also request a copy of the W4 form completed with the employer name, TIN, employee name, and authorized representative's signature. In those situations that may cause concern regarding an employer/employee relationship, the contractor has discretion to request the applicant provide a copy of the W-2 at the

end of the year to verify this information. For those applicants who check 1065-K1, the contractor can request a copy of the Partnership agreement to verify the arrangement.

If any information is missing, request that the applicant provide the missing information. (See §14.1)

7.4 - Practice Location - (Rev. 29, 07-26-02)

4. Practice Location

This section is to identify where the individual will be practicing within the group. Once the individual provides this information, verify that the group application reflects all those practice locations as listed. If not, request the group to update its enrollment application, Form CMS-855B.

In situations where a new physician is joining an existing group, and the wrong date is entered in this section, the applicant must resubmit this section of the form in writing with the appropriate date. In a situation where an existing member of the group is adding a new practice location and a wrong date was entered, obtain this date by telephone to make the correction.

7.5 - Statement of Termination – (Rev. 29, 07-26-02)

5. Statement of Termination

This section allows the individual practitioner to terminate his/her previous authorized reassignment of benefits. Verify that the signature matches his/her original signature on the Form CMS-855. Both the contractor's system and UPIN registry must be updated to show the termination.

7.6 - Reassignment of Benefits Statement – (Rev. 41, 05-23-03)

6. Reassignment of Benefits Statement

The individual practitioner must complete this section to reassign his/her benefits. Follow instructions in MCM Part 3, §3060 to ensure that the group is eligible to receive payment. The group must provide a copy of the reassignment of benefits statement for each physician in order to receive benefits. V*erify the signature of the physician/practitioner in this section against the signature on his/her Form CMS-855I.*

7.7 - Attestation Statement – (Rev. 41, 05-23-03)

7. Attestation Statement

The applicant must sign the attestation statement. If the attestation statement is not signed, return the application. A photocopy or fax signature is not accepted. File the signature copy with the original. The requirements to be an authorized official are defined in §3.15 of this manual. V*erify the signature and name of the authorized/delegated official in this section against the signature and name on Form CMS-855B. The effective date of a reassignment is the date that the individual began or will start rendering services with the group. This information is listed in Section 4 of the Form CMS-855R.*

8 - Enrolling Certified Suppliers Who Enroll With Carrier – (Rev. 41, 05-23-03)

Enrolling Ambulatory Surgical Centers (ASCs), Portable X-ray Suppliers, and Independent CLIA Labs.

For certified suppliers, request an application for every state in which it is rendering services. Upon notification from CMS, carriers will provide initial Form CMS-855 distribution for ASCs, Portable X-ray suppliers, and independent CLIA labs. The carrier shall answer all applicant inquiries concerning the enrollment process. The carrier shall advise the applicant to promptly contact the applicable state agency for its supplier type. Within ten (10) calendar days of receipt of the completed Form CMS-855, transmit a copy of the applicant's Form CMS-855 to the applicable state agency or CLIA office. Document this has been completed. Process the application the same as the Form CMS-855B outside of these instructions

For ASCs and Portable X-ray suppliers review the application and send a recommendation for approval or denial (see §14 regarding recommendations for approval or denial) to the applicable state agency and RO, or make a request from the supplier for additional information. Keep a record of the date the applicant has been recommended for approval. Provide the RO with a copy of applicant's latest updated Form CMS-855. The recommendation sent to the state agency has to have the Form CMS-855 attached only if it has been changed from the one you previously sent to them.

For ASCs and Portable X-Ray suppliers, if the applicant's address and or telephone number cannot be verified by use of Qualifier.net then contact the applicant. If they advise that the facility or Base of Operations and its phone number have not yet been completed, continue processing the applicant and annotate the file. However, a note shall be placed on any recommendation for approval that the address and telephone number of the facility could not be verified pending completion of the facility. In this case, the Date Started at this Location item can also be left blank.

For ASCs and Portable X-ray suppliers you will receive a document or notification that the supplier has met any qualifications required to obtain enrollment. This document is usually an approval letter or tie in notice. The supplier usually also receives a letter notifying it of its meeting any required qualifications.

Upon receipt of a tie-in notice or approval letter from the RO you may enroll the ASC or Portable X-ray supplier. The date claims payment can start is shown on the notice. Do not enroll any supplier who requires an approval or tie-notice until you have received the notice.

CLIA Labs

Labs that are integrated into a supplier or provider, e.g. labs that have exactly the same ownership and physical location as another enrolled supplier or provider (i.e. hospital lab or a lab at a physician's office) do not require a separate Form CMS-855. The enrolled, or enrolling provider or supplier must provide its CLIA number in the practice location section, block 4A5. Independent CLIA labs must submit a separate Form CMS-855. Distribute the initial Form CMS-855 and advise the applicant to contact the applicable CLIA office. Its application must be reviewed as any other supplier. However, it cannot be enrolled until it receives a CLIA number. Check for a notarized or certified true copy of the CLIA certificate or state license. Once the independent CLIA lab has been reviewed and has a valid CLIA number it can be enrolled.

Labs that do not plan to Participate in the Medicare program must be directed to the applicable CLIA office.

Changes of Ownership – The following is a recommended but not currently mandatory procedure. At the current time the carrier may use its discretion in handling these ownership changes. As suppliers ASCs, Portable X-ray suppliers and independent CLIA labs cannot have a formal CHOW as defined in 42 CFR 489.18. When ownership for one of these entities changes, as evidenced by use of a new TIN, the new owners must enroll as a new supplier. Promptly suspend payment to an ASC, CLIA lab or Portable X-ray supplier who has changed ownership. *If applicable,* transmit a copy of the Form CMS-855 for the new owners to the applicable state agency within 10 calendar days of your receipt. Promptly review the Form CMS-855. If the new owners are eligible for Medicare enrollment, contact the state agency to determine if there are any objections or impediments to enrollment of the new owner as a new supplier. Document the state agency's response. If the state agency says it is acceptable to enroll the new owners, then promptly enroll them and pay all suspended claims. If the state agency has questions about whether the applicant must be surveyed, or whether it should have a license, do not enroll the new applicant. Contact the RO for advice on the action to take. If the contractor does not receive a response from the state agency or CMS RO within 10 calendar days, or it requests that the application be held pending further state action, then the delay caused by this is considered excusable for processing time purposes. However, document the file to explain the reason for delay.

The application verification procedures must follow those that are outlined in the supplier section.

NOTE: *The above requirements may vary based on state and RO requirements.*

9 - Medicare + Choice and other Managed Care Organizations – (Rev. 29, 07-26-02)

Managed Care Organizations (MCOs) that have contracts with the Centers for Medicare & Medicaid Services (CMS), including Medicare + Choice Organizations (M+COs), are allowed to bill Part B fee-for-service under certain situations. These situations are detailed in §7065 of the MCM. Such fee-for-service claims would include services provided by the MCOs to a

beneficiary under the following situations: (1) the beneficiary has enrolled with the MCO but their enrollment is not yet effective; (2) services are provided by an attending physician or the services are furnished to an MCO enrollee that are unrelated to a terminal illness and the beneficiary has elected hospice benefits; and, (3) services furnished to a MCO enrollee that are excluded from the MCO contract under section 1852(a)(5) of the Social Security Act.

Since MCOs undergo a stringent application process and are scrutinized closely by RO and CO staffs before admission, carriers will enroll them using an abbreviated Form CMS-855B process. When contacted by an MCO, carriers must send them a copy of the Form CMS-855B and instruct them to complete sections 1A, 2A(1), 2B, 2C, 4A, 4F, 8, 9, 10, 13, 15, and 16 (if applicable). *MCOs do not have to fill out sections 4D since their CO application must describe their record keeping system through which the beneficiary information is accumulated, and it must be readily available to appropriate officials.* The MCO must also attach a copy of the letter issuing the indirect billing number from CO as well as include its contract number (H----). If the organization does not have an indirect billing number, return the application to the MCO and advise them to contact the Health Plan Benefits Group at CMS who will issue the indirect billing number. When it is received, the MCO can resubmit the enrollment package.

The Medicare carrier is only required to verify that the *"practice location"* information is appropriate. The MCO must enter the county/parish, state and zip code where Medicare beneficiaries will be treated for locality payment determinations. Enroll the organization as a multispecialty clinic or group practice and issue it a billing number. Carriers must ensure that the MCO understands that it will receive different billing numbers from each Carrier with whom it enrolls.

Whenever a MCO reduces a geographic area or terminates its entire contract, CO will inform the provider enrollment contacts at each RO. Upon receipt of a termination notice, the MCOs lose all Medicare billing privileges, effective December 31 of that year. The plan that leaves the MCO arrangement will have to complete a new Form CMS-855B in order to qualify for complementary fee-for-service billing privileges that they may be eligible for under § 7065. The plan will submit a new Form CMS-855B and go through a verification process with each carrier with whom it desires to do business.

Notify the organization that all of its contracted physicians and eligible non-physician practitioners must also have a UPIN and a PIN in order for the MCO to receive payment under the indirect payment procedures. The MCO must submit some 855Rs for their physicians at the time of enrollment or prior to the first claim being filed for the physician rendering the service. The MCO does not have to submit 855Rs for all their contracting physicians at the time of enrollment. *The CO contract with MCOs requires a MCO to give detailed names and addresses on all of their providers/suppliers.* The following instructions concern some of the different enrollment situations that may arise:

- An individual is enrolled with the carrier and has a PIN for his/her private side business but he/she also has a contract with a MCO: have him/her submit a Form CMS-855R for his/her Participation with the MCO prior to the first claim is submitted for services

rendered by this individual. This also applies to specialists outside of the MCO who see MCO enrollees.

- An individual contracting with an MCO must enroll with each carrier with which the MCO could be doing business and the individual will be submitting claims to that carrier. A Form CMS-855I and Form CMS-855R are required. The carrier shall verify state license if the individual is already enrolled in Medicare. Otherwise, all information must be verified.

- An individual has never enrolled in Medicare: must fill out a Form CMS-855I and go through entire verification process and submit a Form CMS-855R for reassignment purposes.

Durable Medical Equipment--If a MCO wants to bill for durable medical equipment, prosthetics, orthotics, or supplies (DMEPOS) related to the care it has given an enrollee and which falls under the indirect payment procedure, then it must contact the National Supplier Clearinghouse (NSC). (The NSC will send Form CMS-855S for the MCO to complete sections 1A, 2A, 2B, 2C, 4A, 4B, 4C, 5B, 6A, 8, 9, 13, 15, and 16 (if applicable). Form CMS-855S must be returned to the NSC with a copy of the letter conveying the indirect billing number issued by the CMS. The above termination instructions apply for DMEPOS also.

10 - Application Sectional Instructions for Intermediaries – (Rev. 41, 05-23-03)

These instructions are written to provide guidance to Medicare intermediaries on how to process the enrollment application, Form CMS-855A, Application for Health Care Providers that will Bill Medicare Fiscal Intermediaries.

The intermediary shall insure that all applicant CMS-855A submissions are in accordance with the directions on the CMS-855A except as stated otherwise in this manual or as directed by CMS provider enrollment personnel from the regional or central office. When given special directions from RO or CO provider enrollment personnel, the intermediary should document the file with the instruction given, the name of the person providing the instructions, and the applicable date when the instruction was given.

Routine use of more than one individual to review an application should be restricted to processing where one individual performs one function and the other individual performs a different function. An example would be where one person prescreens the entire Form CMS-855A and one person does all the verification checks. (For more information on the processing cycle, see §15). Any time the contractor requests information from an applicant, provide the applicant with a name and contact person so the applicant can reach the contact person directly. Each "provider-based" HHAs/hospice must submit its Form CMS-855A application to the audit intermediary (intermediary of the parent provider). Any other HHA or Hospice providers must submit its Form CMS-855A applications to the regional home health intermediary (RHHI).

10.1 Processing the Application – (Rev. 41, 05-23-03)

Section 1. General Application Information. - Form CMS-855A

The applicant must state the reason for submitting the application.

A. Reason for Submittal of this Application

1. Check one:

If the applicant fails to check any of the boxes to indicate why the application is being submitted, review the application to determine the reason for submittal. If the contractor can make that determination on its own, continue to process the application. If not, contact the applicant by telephone for additional information; see § 6.

Initial Enrollment--Any provider who enrolls in the Medicare program for the first time with the contractor under this tax identification number or who has already enrolled with a contractor but needs to enroll in the contractor's jurisdiction would check this box. Also, if a provider is seeking to reestablish itself in the Medicare program after reinstatement from an exclusion, the applicant would enroll as if it were an initial enrollment. Although the application would be checked as an initial enrollment, the provider retains its original billing number so that you can continue to track its performance.

Reactivation - We will not deactivate any providers enrolled with a FI (except for CMHCs) or providers who are certified with a carrier (ASCs, Portable X-Rays and independent CLIA). The contractor (FI or Carrier) shall identify these enrolled entities who have not billed for four consecutive quarters. However, this is not applicable if the contractor system cannot identify these entities on an automated basis. The contractor shall attempt to ascertain if the entity is still in existence. *They shall do this via Qualifier.net review, telephone contact, letter submission and, if necessary, on-site review*. Enrollees who appear to be no longer in business should be referred to the RO and the state agency. If the enrollee appears to still be in business, take no further action. Document the process.

See §11.3 of these instructions for guidance on the deactivation of CMHCs.

Change of Information--Any time a currently enrolled provider is adding, deleting, or changing information under the same OSCAR number, it must report this change using the Form CMS-855A. *The requirements for processing the change are shown in §13, Changes of Information.*

Any change to a Pay-to-Address requires the contractor to verify/validate this request. See §4C "Pay-to-Address" for further instructions.

Voluntary Termination of Billing Number--Effective Date (MM/DD/YYYY).--When a provider will no longer submit claims to the Medicare program, we allow it to voluntarily terminate its number. This is to prevent any fraudulent abuse of the number. Therefore, we are requesting that

the applicant notify the program in the event the provider closes its business, etc. The applicant should provide the date it stopped practicing under this number. For any provider that is placed on a corrective action plan, it cannot deactivate its billing number to circumvent its agreement with Medicare.

Change of Ownership (CHOW), Acquisitions and Mergers, Consolidations

Due to the complicated rules concerning these actions, some applicants will incorrectly check the wrong enrollment box. Use the following rules, as well as the information provided by the applicant and the Form CMS-855A instructions, to determine which enrollment action is being undertaken. After this review, if it is determined that the applicant has checked the wrong box, make a request for additional information so that the applicant can make the appropriate changes.

All subunits which have a separate OSCAR number and provider agreement are required to submit their change in status (CHOW, Acquisition/Merger, Consolidation or Voluntary Termination of Billing Number) on a separate Form CMS-855A for said subunit. However, intermediaries are encouraged to process together all Form CMS-855s applicable to the change in status. For example, all the owners listed on the numerous Form CMS-855s for the basic provider and numerous subunits can receive one check against the FID (IF APPLICABLE).

Providers who are changing their intermediary as a result of a CHOW, acquisition, merger or consolidation should submit the information to the new intermediary of preference. *This request, which is required to be submitted by Form CMS-855A, should be promptly processed by the new intermediary*. However, the provider should also request a change of intermediary from the RO. If an FI receives an 855A for a CHOW that requires a change of intermediary*, it* should contact the provider and advise *it* to contact the current RO for a change of intermediary. The new intermediary shall contact the outgoing intermediary and provide them with the submitted information. If the provider mistakenly submits the CHOW information to the old intermediary, the old intermediary shall contact the new preferred intermediary and forward the submitted information. The new intermediary shall note on any recommendation for approval if a required change of intermediary request has not yet been approved by the RO.

NOTE: CHOW determinations are the responsibility of the RO unless *otherwise* delegated.

Change of Ownership (CHOW)

Applicants that are undergoing a CHOW- this includes the old and new owners- should check this box. The old and new owners should submit separate Form CMS-855s. To determine if the enrollment activity being reported is actually a CHOW, consult 42 CFR 489.18. *and* SOM §3210.

If a prospective or new owner does not accept assignment of the liabilities and assets of the old owner, then the new owner cannot have the provider agreement transferred to it. It will be considered a new applicant. This new owner should not check the CHOW box. It should check initial enrollment.

*In addition, m*any providers/suppliers undergo financial and administrative changes that they may consider to be a CHOW but do not meet the definition shown in 42 CFR 489.18. The changed information shall be reported by submission of an update of the applicable changed sections of this form. They should check the Change of Information box in §1 of the application.

Acquisitions/Mergers

Applicants reporting actions that will result in one or more provider (OSCAR) numbers being eliminated from the Medicare program should check the "*Acquisition/Merger"* box. In general, a provider number is eliminated if the acquisition results in only one remaining Tax Identification Number (TIN), state survey or accreditation, and Medicare agreement. If the acquisition results in an existing provider having new owners but keeping its same provider number, then the applicant should check the CHOW block.

The acquisition box should be checked on separate Form CMS-855s by both, 1) the provider that is acquiring another provider, and 2) the provider that is being acquired by another provider.

Consolidations

This box should be checked when (and only when) a consolidation will result in issuance of a brand new provider number. This is usually the result of formation of a brand new organization, with a brand new TIN. All applicable sections of this application should fill out for this brand new provider entity (similar to being an initial enrollment).

1. Tax Identification Number/Medicare Identification Number-§1124(a)(1) and 1124A(a)(3) of the Social Security Act requires both SSNs and EINs be obtained. The Social Security Administration (SSA) and the Secretary of the Treasury, through the IRS, will verify that the SSNs and EINs that are collected match the disclosing entity on the application. This automatic verification will occur when the PECOS becomes operational. According to IRS requirements, a TIN is a SSN or an EIN, and appears with the legal business name used when reporting taxes to the IRS. Validate the TIN against IRS paperwork, such as a CP575 (a computer-generated form), a Form 990, a quarterly tax payment coupon, or other IRS correspondence which contains the applicant's name and the TIN. If an applicant cannot obtain the required IRS document, then an explanation must be given in a separate attachment and evidence provided that links the business name with the TIN listed. An applicant may request a verification letter (IRS 147c) from the IRS of their TIN and legal business name. *(For example, if a provider changes its name, and the IRS does not send an updated document.)* The provider may then submit the old IRS document with the old name, and a copy of documentation filed with the state or IRS concerning the name change with an explanation of the situation. If the applicant fails to provide this information or it does not match, make a recommendation for denial. See §14.3, denial 6.

2. Medicare Identification Number-This block must be filled in by all currently enrolled providers. This block is usually checked as a result of a sale to an owner that is enrolled or will request enrollment with you. Sometimes, it will be checked by an enrollee for "other" reasons. In either case, contact the current intermediary of the provider to advise them of the proposed change. Request that the current intermediary provide the information regarding the provider's

status with the intermediary, i.e., overpayments, pending adverse action or existing adverse action against the provider, owner, managing employee, etc. The responding intermediary must provide an answer concerning the inquiry within 5 days absent extenuating circumstances. Do not delay processing the application. However, if the other intermediary indicates suspicion or existence of fraud or abuse, or other problems, alert Benefit Integrity/PSC. Check the FID (if applicable). Contact the OIG if necessary. This information should be brought to the attention of the RO before any formal CHOW or change of intermediary is permitted.

3. FI Preference*:*

a.) A new provider would complete this block*;*

b.) A provider who is enrolled and is requesting a change would check this block*; and*

c.) An applicant can complete this block with its intermediary preference. If there is reason to believe that the provider should be enrolled with another intermediary, contact the RO. The provider is not always assigned its intermediary of preference.

A provider that is just requesting a change of intermediary does not have to submit Form CMS-855A. *It* can just contact the RO. Providers who are changing their intermediary as a result of a CHOW, acquisition, merger, or consolidation should submit the information to the new intermediary of preference. However, the provider should also request a change of intermediary from the RO. If an FI receives an 855A for a CHOW that requires a change of intermediary they should contact the provider and advise them to contact the current RO for a change of intermediary. The new intermediary shall contact the outgoing intermediary and provide them with the submitted information. If the provider mistakenly submits the CHOW information to the old intermediary, the old intermediary shall contact the new preferred intermediary and forward the submitted information. The new intermediary shall note on any recommendation for approval if a required change of intermediary request has not yet been approved by the RO. *This note should be distributed to the outgoing intermediary and corresponding RO, and the potential incoming RO. If the change of intermediary request is not granted, then the intermediary who processed the CHOW should supply Form CMS-855A(s), and corresponding verification documentation to the intermediary who will retain the provider.*

B. Change of Ownership Information (CHOW Only)

Providers that are undergoing a change in their ownership structure are required to notify us concerning the identity of the old and new owners, how they will organize the new entity, and when the change will take place. In general, we require separate Form CMS-855 notification from both the old and new owners. There are basically five types of changes that can occur: 1) A CHOW in accordance with 42 CFR 489.18; 2) Changes in the ownership structure to an existing provider which do not constitute a CHOW; 3) A new owner who purchases an existing provider but will not accept assignment of the assets and liabilities of the old provider (a new provider); 4) An existing provider who acquires another existing provider (acquisition/merger); and 5) Two or more existing providers who are totally reorganizing and becoming a new provider (consolidation).

The intermediary shall document that all individuals who are processing CHOWs, Acquisitions, and Consolidations are familiar with 42 CFR 489.18 and all other CMS directives concerning these actions.

In processing an action concerning blocks B, C, or D, it is possible that the applicant will make a mistake concerning the type of transaction *it is* having. In some cases, this will require a request for additional information from the applicant. If this happens, continue to process the application and request that the applicant revise the application. A major goal in processing these transactions is to ensure that we have current information on any new owners. We also want to be certain that we are not paying a new owner who does not accept assignment until he/she is separately enrolled.

Information submitted from an old and new owner on separate Form CMS-855s should be checked against the information for the same entity submitted by the other owner(s). In Particular, the intermediary shall attempt to assure that both the old and new owners report these changes. This can be done by waiting no more than 14 calendar days after receiving Form CMS-855 from one set of owners and then calling/notifying the ownership entity that has not yet reported the change.

We are willing to accept information concerning prospective changes up to three months prior to the anticipated date of *the* prospective change. The applicant can make changes to its submitted Form CMS-855 during the review period. It must notify us within 30 days of any change. Reported changes should be reviewed immediately.

NOTE: Final CHOW determinations are the responsibility of the RO, unless *otherwise* delegated.

1B. Change of Ownership Information (CHOW Only)

For old/selling owner--The intermediary shall check to determine that an enrolled provider (seller) that will transfer its ownership interest to new owners and undergo a CHOW in accordance with 42 CFR 489.18 has completed this section. This "old" owner should check the CHOW box in Section 1A1, complete item 1B, and sign the Certification Statement in §15. *If a certification statement is not on file for the old owner, then request that they fill in section 6 for only the individual who is signing the certification statement. Check this individual against all applicable databases including Qualifier.net.* Form CMS-855s from the old owners citing a CHOW does not require a recommendation for approval or denial. Those recommendations will be based upon the CHOW application received from the prospective new owner. The old owner's Form CMS-855 *should only be entered on the logging and tracking (L&T) screen on PECOS as a CHOW. An enrollment record for the old owner is not required.*

If a Form CMS-855 is not received from the new owner within 14 calendar days of receipt of the Form CMS-855 from the old owner, contact the potential new owner. Document this action. Use information from the sales agreement, call the old owner, or use an independent source. If the contractor does not receive information from the new owner that it has accepted assignment and

submitted a Form CMS-855 within 30 calendar days of an attempt to contact the new owner, then stop payments unless the sale has not yet been accomplished. However, payments to *the provider* can then resume once this information is received and you ascertain that it accepts assignment. This can be evidenced by the provider checking "Yes" in block 1B4.

For new/purchasing owner--A prospective or new owner (purchaser) who is Participating in a CHOW as defined in 42 CFR. 489.18 should complete the entire application. It should check the CHOW box in Section 1A1. The FI shall check to see that the information in *1B* has been fully completed. A copy of the sales agreement is required. If the sales agreement is not attached make a request for additional information. The FI shall document that it has reviewed the sales agreement. Document that the information contained in the sales agreement is consistent with that reported to it in the new owner's Form CMS-855. If a final sales agreement has not been submitted, the FI shall still complete its review of the entire application. However, it should hold the application until the final sales agreement has been received and reviewed. Put a note in the file when you are holding an application for only the final sales agreement (include the date that all other processing has been completed). Processing time stops when waiting for the final sales agreement. The FI does not have to revalidate information even if validated information is technically outdated upon receipt of the sales agreement. If the old owner's Form CMS-855 is available at the time of review, then check the information against that received from the old owner. Document that this has been accomplished. However, if the old owner's Form CMS-855 for a CHOW has not been received, contact the old owner. Document the file and make a letter request. Wait at least 10 days for Form CMS-855 from the old owner to be received before processing the new owner's Form CMS-855 without it. In particular, there should be consistency among the names of the relevant Parties to the CHOW. The end result of the review of the new owner's Form CMS-855 application shall be a recommendation to approve or deny. The new owner's Form CMS-855 can be processed with a recommendation even if the old owner's Form CMS-855 for a CHOW cannot be obtained. Do not make a recommendation to approve unless the new owners have checked "Yes" in block 1B4.

New Owner Not Accepting Assignment

If the prospective or new owner does not accept assignment of the liabilities and assets of the old owner, then the new owner cannot have the provider agreement transferred *to it*. If an individual currently enrolled as a provider has a CHOW as a result of their incorporation, they must submit two copies of their Articles of Incorporation in lieu of the Sales agreement. The carrier must review the Articles of Incorporation and document that they have performed this review. The review should be to verify that the Parties involved are those shown on the Form CMS-855A.

In a CHOW, the new owners will be considered enrolled for payment purposes on the latter of 1) the date they passed their state survey or accreditation or 2) the date they were recommended for approval by the FI (therefore, it is very important to annotate that date).

C. Acquisitions/Mergers

Acquisitions that will result in one or more provider (OSCAR) numbers being eliminated from the Medicare program should be reported in this section. In general, a provider number is

eliminated if the acquisition results in only one remaining Tax Identification Number (TIN), state survey or accreditation, and Medicare agreement. If the acquisition results in an existing provider having new owners but keeping its separate provider number, then the instructions in section 1B above for a CHOW are applicable (neither provider should fill out this Section 1C). This section should be completed on separate Form CMS-855s by *b*oth, 1) The provider that is acquiring another provider, and 2) The provider that is being acquired by another provider.

- Provider Being Acquired: All providers being acquired should be listed.

- Acquiring Provider: This section is to be completed by both the acquiring and the acquired organization with information concerning the acquiring provider.

Provider Being Acquired

The provider being acquired should check "Acquisition" in block 1A1 and should provide the effective date of acquisition. It should complete 1C*1* and *1C2* sign the certification statement. Form CMS-855As from the old owners citing an "Acquisition" do not require a recommendation for approval or denial. Those recommendations will be based upon the Acquisition application received from the prospective new owner. The old owner's Form CMS-855A will be *considered a CHOW for PECOS purposes. If a certification statement is not on file for the old owner, then request that they fill in Section 6 for only the individual who is signing the certification statement. Check this individual against all applicable databases including Qualifier.net.*

If the Form CMS-855A is not received from the new owner/acquiring provider within 14 calendar days of receipt of the Form CMS-855A from the old owner/provider being acquired, contact the potential new owner. Document this action. Use information already on file, call the old owner, or use an independent source. If the FI does not receive information from the new owner, and an updated Form CMS-855A from it within 30 calendar days of the attempt to contact the new owner, then stop payments to the old provider number unless the effective date has not been reached. However, payments to *the old number* can then resume once this information is received.

Acquiring Provider

The provider doing the acquiring should completely fill out items 1. and 2. However item C does not need to be completed if no sub-units are on file. The provider doing the acquiring should also amend §4, "Practice Location", to list the practice location of the provider it is acquiring. The application from the acquiring provider should be thoroughly reviewed. If the old owner's Form 9-855 for an Acquisition has not been received, contact the old owner. Document the file and make a letter request. Wait at least 10 days for Form CMS-855 from the old owner to be received before processing the new owner's Form CMS-855 without it. The intermediary shall check for consistency and document the file with the result of checking the information provided by the new owner's Form CMS-855 against that provided by the old owner's Form CMS-855 for an Acquisition (if available). A copy of the sales agreement is required. If the sales agreement is not attached make a request for additional information. The intermediary shall document that it has reviewed the sales agreement. The intermediary shall document that the information contained in

the sales agreement is consistent with that reported to it in the new owner's Form CMS-855. If a final sales agreement has not been submitted, the intermediary shall still complete its review of the entire application. However, it should hold the application until the final sales agreement has been received and reviewed. Put a note in the file when you are holding an application for only the final sales agreement (include the date that all other processing has been completed). Processing time stops when waiting for the final sales agreement. The intermediary does not have to revalidate information even if validated information is technically outdated upon receipt of the sales agreement. The end result of the new owner's Form CMS-855 review should be a recommendation to approve or deny. This can be issued even if you do not receive Form CMS-855 from the old owner. You may request additional information from the new owners as applicable.

If you ascertain by any means that a provider who is currently enrolled has acquired another enrolled provider, immediately request Form CMS-855A reflecting the acquisition, from the provider doing the acquiring. If the provider doing the acquiring does not submit this Form CMS-855A within the later of the date of acquisition or 30 days after the request, stop payments to the acquiring provider. Payments may be resumed upon receipt of the completed Form CMS-855. Document attempts to contact the acquiring provider.

D. Consolidations (including their CHOWs)

This item should be completed only when a consolidation will result in the issuance of a brand new provider number. This is usually the result of formation of a brand new organization, with a brand new TIN. All applicable sections of this application should fill out for this brand new provider entity (similar to being an initial enrollment). The result of the review of the new consolidated provider shall be a recommendation to approve or deny, or a request for additional information.

Consolidations that will result in two or more provider (OSCAR) numbers being eliminated from the Medicare program should be reported in this §1D. In general, a provider number is eliminated when a TIN is eliminated. If a transaction results in an existing provider having new owners but keeping its separate provider number, then the instructions in section 1B above for a CHOW are applicable. If a transaction results in an existing provider having new owners and it will still be using the provider number of the acquirer, then the instructions in §1C above for an Acquisition are applicable.

1. 1st Consolidating Provider

This section should be completed about the 1st currently enrolled provider who, as a result of this consolidation, will no longer retain its current Medicare provider number.

2. 2nd Consolidating Provider

This section should be completed about the 2nd currently enrolled provider who, as a result of this consolidation, will also no longer retain its current Medicare provider number.

3. Newly Created Provider Identification Information

Complete information should be provided about the newly created provider. *This Form CMS-855A should be handled as an initial application for PECOS purposes.* Each provider who will no longer be enrolled as a Medicare provider as a result of the consolidation should also submit a Form CMS-855A which checks "consolidation" in block 1.A.1. *Each provider being consolidated* should complete block 1.D.1. and sign the certification statement. If you receive Form CMS-855A from a provider being consolidated, it should be *considered a CHOW for PECOS purposes and does not require a recommendation for approval or denial. If you do not have a certification statement on file for the old owner, then request that they fill in section 6 for only the individual who is signing the certification statement. Check this individual against all applicable databases including Qualifier.net.* If any of the old owner's Form CMS-855's for a Consolidation have not been received, contact each corresponding old owner. Document the file and make a letter request. Wait at least 10 days for Form CMS-855 from the old owner to be received before processing the new consolidated owner's Form CMS-855 without it. The intermediary shall check for consistency and document the file with the result of checking the information provided by the new consolidated owner's Form CMS-855 against that provided by Form CMS-855s for Consolidation from the old owners (if available). Do not make a recommendation to approve or deny until the new consolidated entity has actually been established. Processing time stops when waiting for the new consolidated entity to be formally established. The end result of the new consolidated owner's Form CMS-855 review should be a recommendation to approve or deny. This can be issued even if you do not receive Form CMS-855s from the old owners. The contractor may request additional information from the new owners as applicable. The review of Form CMS-855A for the new Consolidated provider shall be the same as for any new provider (all applicable sections should be completed and reviewed).

If the contractor does not receive a Form CMS-855A from the new consolidated provider within 14 calendar days of the contractor's receipt of the Form CMS-855A from an old owner/provider being consolidated, contact the potential new owner. Document this action. Use information already have on file, call the old owner, or use an independent source. If the contractor does not receive information from the new owner, and an updated Form CMS-855A from them within 30 calendar days of the contractor's attempt to contact the new owner, then suspend payments to the old provider numbers unless the consolidation has not been accomplished. However, payments to *the old number* can then resume once this information is received.

If the FI ascertains by any means that a provider who is currently enrolled has or is taking Part in a consolidation, immediately request *(from the new consolidated provider)* a Form CMS-855A reflecting the consolidation, from the new consolidated provider. If the consolidated provider does not submit this Form CMS-855A within the latter of the date of consolidation, or 30 days after the request, stop payments to the old provider number. Payments may be resumed upon receipt of the completed Form CMS-855. Document attempts to contact the consolidated provider.

Questioning CHOW, Acquisition (including Merger) or Consolidation Status

Sometimes the FI will question whether a CHOW, Acquisition, or Consolidation has occurred. The CMS RO has the final authority to make the determination as to whether these have occurred.

The FI shall process all CHOW, Acquisition and Consolidation applications, and change of information applications which could potentially be a CHOW, Acquisition or Consolidation, to the maximum extent possible prior to any RO determination. The intermediary shall promptly contact the RO. Such contact, via a letter, e-mail or telephone call shall be documented. If the RO does not respond to the contractor's request within 10 calendar days, any additional days shall be considered a valid processing time extension. The intermediary shall document the date that the response was received.

10.2 - Provider Identification – (Rev. 41, 05-23-03)

Section 2: Provider Identification

A. Type of Provider

1. Check One

Verify that the provider is licensed to *furnish services* in the state where it is enrolling.

If the applicant submits the license without it being notarized or "certified true," verify the license with the appropriate state agency. A notarized copy of an original document will have a stamp which states "official seal" along with the name of the notary public, State, county, and the date the notary's commission expires. A certified "true copy" of an original document obtained from where it originated (or stored) has a raised seal which identifies the state and county in which it originated or is stored. All applicable licenses must be submitted and verified as valid. If the state has a licensing body that issued the applicant a certificate of good standing, recognize it as adequate proof the provider has received the license required. However, the certificate of good standing cannot be older than 30 days.

The license(s) which should be submitted with this application are only those required by Medicare or the state to function as the provider type for which the applicant is applying. Local licenses/permits (in Particular those not of a medical nature) are not required. Documents that can be obtained only after state surveys or accreditation are not required as Part of the application submissions.

If the applicant had a previously revoked or suspended license reinstated, request that the applicant submit a copy of the reinstatement notice(s) with the application.

If the applicant does not submit the appropriate license information, except for licenses available only after state surveys or accreditation, make a recommendation for denial; see §14.3, Denial 2.

2. This block is to be completed only by hospitals.

3a. All hospitals must check a box for this item. If the contractor believes that a listed department is not really a department that would qualify as being provider-based, then request additional information from the provider.

3b. All hospital applicants must complete this item.

HHA and Rehab Extension Sites

If an existing HHA or Rehab wants to add a branch/extension site, it is considered a change of information. However, if the HHA adds a subunit, *the subunit* needs a provider agreement and must be considered an initial application. A branch is a location or site from which an HHA provides services within a portion of the total geographic area served by the parent agency. The branch is Part of the HHA and is located sufficiently close to the parent agency, so that it shares administration, supervision, and services with the parent agency. A subunit is a semi-autonomous organization under the same governing body as a parent HHA that serves patients in a geographic area different from that of the parent agency. The parent agency, because of the distance between it and the subunit, is incapable of sharing administration, supervision and services with the subunit on a daily basis. The contractor's RO may assist in distinguishing a branch from a subunit.

Hospitals *that* are enrolled and are adding a rehabilitation or psychiatric unit do not have to complete an entire Form CMS-855A to accomplish this. They should submit a change of information, in accordance with the section 13 instructions, showing that they are adding the unit and/or adding any additional managers, etc.

B. Provider Identification Information

1. Verify that the legal business name reported is the same name reported to the IRS as described in §1A2. If the legal business name is different than what is reported to the IRS, request additional information for clarification after finished reviewing it; see §14.1. The provider must provide at least one document from the IRS showing the legal business name it uses to report taxes to the IRS with the corresponding TIN. If an applicant cannot obtain the required IRS document, then it should explain why in a separate attachment and provide evidence that links its *legal* business name with the TIN listed. For example, suppose the applicant recently change*d* its name and the IRS has not *yet* sent it an updated document. The applicant may submit the old IRS document with the old name, as well as a copy of documentation filed with the state concerning the name change. Additionally, it should submit a note explaining the situation. If the applicant does not provide a valid TIN, recommend denial to the RO, see §14.3., Denial 6.

The legal business name shown in this section is usually the only business or individual name which is required to be verified against its TIN through use of an IRS document. It is not routinely required to check other owners, managers or directors in section 5 and 6 of the CMS-855A against an IRS document. However, for providers where the legal business of the entity owning the provider is shown only in section 5 or6, then that name only must be checked against an IRS document.

2. Capture the "doing business as" name as reported and the county/parish where the name is registered (if applicable).

3. Identify the business structure of the provider.

4. Annotate the year-end cost report date and the date the business started. If these are not completed, contact the applicant for additional information; see §14.1.

5. Verify the incorporation date and the state where incorporated with *Qualifier.net.* If a discrepancy is found, contact the applicant for additional information; see §14.1.

If the business is incorporated, and the contractor finds information *conflicting with* what is reported, request a copy of the provider's "Articles of Incorporation" for validation purposes.

C. Correspondence Address

This section is to assist in contacting the applicant with any questions or concerns with the application. This must be an address where the applicant can be contacted directly to resolve any issues that may arise as a result of its enrollment in the Medicare program. It cannot be an address of a billing agency, management services organization, or staffing company.

Verify that the telephone number on the application is a number where the contractor can directly contact the applicant. Call the number on the application to verify that this is the applicant's personal number. If the applicant has not provided this information, attempt to contact the applicant by telephone by the number provided under *the* practice location. If the contractor cannot make contact with the applicant, request additional information. If the applicant has supplied a billing agency's address, again try to contact the applicant at the practice location. If the contractor is unable to reach the applicant directly, request additional information.

D. Accreditation

The provider must check, *one of the boxes*. If the provider cites *"Yes"* or *"Pending,"* check to see if the accrediting body cited is one which CMS accepts in lieu of a state survey or other certification for the provider type being enrolled. If the accrediting body is not one those accepted by CMS in lieu of *a s*tate survey, advise the provider accordingly and document the file. The provider may cite that the accrediting action is in addition to another CMS recognized certification. This is acceptable.

E. Federal Approval (FQHCs and OPOs only)

Check to see that the prospective provider has checked "Yes," *"No,"* or "Pending" in this block. Continue to process the application even if the block has been checked "No" or "Pending." However, if the applicant has not notified you that it has received *the necessary* approval, attach a note, to the recommendation for approval or denial you send to the RO.

F. Prospective Payment *S*ystem *E*xclusions

The applicant should check *"Yes"* or *"No"* in this block. If the block is not checked, make a request for additional information. However, if the block is left blank by a provider type that cannot have prospective payment system excluded units, ignore this block.

G. Comments

This section is to explain any unique billing number requests or to clarify information in this section.

10.3 - Adverse Legal Action(s) – (Rev. 41, 05-23-03)

Section 3. Adverse Legal Actions and Overpayments

A. Adverse Legal History

Check to see whether the applicant is changing previous information. If yes, make sure that the effective date is listed. If the applicant fails to provide you with an effective date, request additional information; see §14.1.

1. The provider must respond to this question, either checking "Yes" or "No." If the applicant indicates that it has had an adverse legal action imposed against it but Qualifier.net (which contains MED and GSA data) does not report this, contact the OIG and/or Benefit Integrity/PSC to determine whether this can and should form the basis of an exclusion. Hold (but continue processing) the application until the OIG decides whether the adverse legal action should result in an exclusion. If the OIG imposes an exclusion, recommend denial to the RO. If not, continue to process the application and make a recommendation.

The Fraud Investigation Database (FID) must be checked for all applicants, managers, directors/owners, etc. when it is noted that the above individuals/entity has or has had a Medicare identification number. Therefore, if there is no indication that the individuals/entity ever had a billing number, do not check the FID. If the applicant states that it has never had a Medicare identification number but the contractor finds it has, check the FID. If the applicant appears on the FID but is not excluded, process the application according to §16.1.

Check the name, tax identification number, and/or Medicare/Medicaid numbers against Qualifier.net, FID (IF APPLICABLE), and HIPDB. The provider must be checked against the aforementioned lists regardless of whether it states in this section that it has never had an adverse legal action imposed against it. If the provider is excluded or debarred according to Qualifier.net, process the application to capture all the information reported in the enrollment system but recommend denial of the application, and explain the reason(s) for denial; see §14.3., Denial 1. Contact any other intermediaries that may have enrolled the applicant to ensure that no future payments are made, that the other intermediaries are aware of the exclusion, and that recoupment actions are taken if appropriate.

If the applicant appears on the FID but is not excluded, process the application according to §16.1. If the applicant appears in the HIPDB, process the application according to §16.2.

2. If the provider indicates that it has had an adverse legal action imposed against it, make sure that the provider furnishes information concerning the type and date of the action, and what court(s) and law enforcement authorities were involved. Also, documentation that evidences the imposition/notification and resolution of the adverse action must be submitted (e.g., notification of disciplinary action, criminal court documents). Refer the application to Benefit Integrity/PSC for further investigation. If the provider was excluded but has since been reinstated, verify this through the OIG and ask the provider to submit written proof (e.g., reinstatement letter) indicating that such reinstatement has in fact taken place. *Anytime an applicant is being reinstated, make sure that the applicant responds "yes" to this question. Failure to respond appropriately to this question would result in a denial. See Denial 8 in §14.3.*

Table A

This table is a list of all adverse legal actions that must be reported in §3A of the application. If an adverse legal action is listed for the applicant and has not resulted in an exclusion, refer this application to Benefit Integrity/PSC for further direction.

B. Overpayment Information

1. If the provider indicates that it has outstanding Medicare overpayments, initiate procedures for collection.

2. The applicant must furnish the name or business identity under which the overpayment occurred and the account number under which the overpayment exists.

Note that overpayments that occur after the provider is enrolled need not be reported unless the provider is enrolling with a different Medicare contractor.

10.4 - Practice Location – (Rev. 41, 05-23-03)

Section 4. Practice Location

The intermediary should consider the following special situations:

Home Health Agencies (HHAs) should complete Section 4A with their administrative address.

Mobile and portable units should not be listed in this section.

CMHCs must list all alternative sites where core services are provided as practice locations (proposed alternative sites for initial applicants and actual alternative sites for those CMHCs already Participating in Medicare). In accordance with provisions of the Public Health Service Act, a CMHC is required to provide mental health services principally to individuals who reside in a defined geographic area (service area). Therefore, CMHCs must service a distinct and definable community. Those CMHCs operating or proposing to operate outside this specific

community must have a separate provider agreement/number and enrollment, and *must* individually meet the requirements to participate. CMS will determine if the alternative site is permissible or whether the site must have a separate agreement/number. CMS will consider the actual demonstrated transportation pattern of CMHC clients within the community to *ensure* that all core services and Partial hospitalization are available from each location within the community.

A CMHC patient must be able to access and receive services he/she needs at the parent CMHC site or the alternative site *that* is the distinct and definable community served by the parent.

A. Practice Location Information

Hospitals must list all addresses where they (not a separately enrolled provider/supplier type, such as a nursing home) provide services which are being billed as provider-based (inpatient and outpatient services). All the locations the hospital lists must be able to qualify as provider-based in accordance with *current* regulations. *The intermediary should not hold up processing of any additional practice locations pending receipt of provider-based attestations or RO concurrence of provider-based status for the practice location(s) being added. The practice location(s) should be listed on Form CMS-855A Change of Information. An exception is when CMS RO specifically requests that the enrollment change be delayed pending final determination of provider-based status.*

Check to see whether the applicant is adding, deleting, or changing previous information. If yes, make sure that the effective date is listed. If the applicant fails to provide you with an effective date, request additional information; see §14.1.

1. The applicant must list each name where services are rendered, including all hospitals and/or other health care facilities in this section. The practice name can be the "Doing *B*usiness *As* Name". The applicant should also provide you the date it started at this location.

2. The provider shall list the complete address of all practice locations where it renders services as its provider type. *If the applicant's address and or telephone number cannot be verified by use of Qualifier.net then contact the applicant. If they advise that the facility and its phone number have not yet been completed, continue processing the application and annotate the file. However, a note shall be placed on any recommendation for approval that the address and telephone number of the facility could not be verified pending completion of the facility. In this case, the Date Started at this location item can also be left blank. For PECOS entry use the date the Certification Statement was signed.*

3. For those providers who are receiving reassigned benefits from contractors, indicate if the provider owns or leases the practice location. For those who received reassigned benefits from *independent* contractors--the contractor must provide the service on-site that the provider owns or leases. For clarification of reassigned benefits, see MIM 3488.

4. The applicant must list any CLIA or FDA Mammography Certification Numbers (if applicable).

B. Mobile Facility and/or Portable Units

If the applicant indicates that it is providing services from a mobile facility or portable unit, it should complete §4C through 4E about the mobile/portable services on Form CMS-855A. If the applicant fails to check this box, continue to process the application and assume it does not operate services from a mobile facility or portable unit. However, if you suspect something different, contact the applicant for additional information; see §14.1.

C. Base of Operations Address

1. The base of operations name and the date the provider started practicing at this location should be captured in this section. If the provider fails to provide this information, request additional information; see §14.1.

2. This address should be one where the personnel are dispatched, where the mobile/portable equipment is stored and, when applicable, where vehicles are parked when not in use. The telephone number, fax number and E-mail address should be captured for the base of operations. If the applicant fails to provide this information, recommend denial to the RO according to §14.3., Denial 3.

If the applicant's address and or telephone number cannot be verified by use of Qualifier.net then contact the applicant. If they advise that the facility and its phone number have not yet been completed, continue processing the application and annotate the file. However, a note shall be placed on any recommendation for approval that the address and telephone number of the facility could not be verified pending completion of the facility. In this case, the Date Started at this Location item can also be left blank.

D. Vehicle Information

This section captures information about the mobile unit when the services are rendered in the vehicle. For portable services (e.g., where the equipment is removed from a van, etc., and is used in a fixed setting), information concerning how the equipment was transported would not be captured in this space. If this section is blank, assume that the services are not rendered inside a vehicle unless there is data that shows otherwise. If this is found, recommend denial to the RO according to §14.3., Denial 3.

1-3. Capture the vehicle information. A copy of all health care related permit(s), license(s), and registration(s) must be submitted for each vehicle reported. If the applicant fails to provide this information, recommend denial to the RO according to §14.3., Denial 3.

E. Geographic Location where the Base of Operations and/or Vehicle Renders Services

1. Initial Listing and/or Additions

This section is to capture where the provider renders services to Medicare beneficiaries from or in its mobile unit. For those mobile units that cross state lines, the provider must complete a separate Form CMS-855A enrollment application for each State. If the applicant fails to provide this information, request additional information.

2. Deletions

The applicant would provide information if it were deleting a location where mobile or portable services were provided.

F. Pay-to-Address

If an applicant indicates that payments are going to an address other than the reported *practice location* mailing address, update the system. This address may be a post office box. If it is determined that payment is being made to an agent, *(see Section 8 of the application)* determine that the billing agreement follows all the requirements outlined in the MIM *§*3488. If the payments are being sent electronically, verify that an EFT agreement has been signed *by the appropriate official listed on Form CMS-855A*. When an EFT agreement is submitted, verify the bank account is in compliance with the MIM *§*3488, Payment to Bank.

Electric Funds Transfer Changes

If an enrolled provider notifies the contractor's accounting department that he/she is changing their account to a different bank, the provider enrollment staff would need to be involved. The accounting department must forward the new Form CMS-588 to the provider enrollment staff. The PE staff must review Form CMS-588 to determine whether all banking information complies with MIM. We view a change to Form CMS-588 as a change to the pay-to-address. If the contractor's accounting department notifies PE staff that they received Form CMS-588, and the provider has never completed an enrollment application, it must complete one. When completing a Form CMS-855, the EFT address may not be reflected in the pay-to-address section of the Form CMS-855A, as this address may be used for hardcopy checks and remittance advices. The intermediary must obtain a complete initial Form CMS-855A. The initial Form CMS-855A must be completely revised/revalidated. The signature on the Form CMS-588 should note that of the authorized official/delegated official on the Form CMS –855A. Therefore, it is required to obtain a complete initial Form CMS-855. If however, the provider has previously completed an enrollment form, the intermediary need only to check the signature on the Form CMS-588 against signatures on the Form CMS-855 on file. This information does not require a "change of information" or a skeletal record for PECOS on the Form CMS-855A. All the validation requirement listed below for a pay-to-address change must be followed. Once verifications are complete, a copy of the Form CMS-588 must be attached to the existing (or initial) Form CMS-855. The original Form CMS-588 can be maintained in accounting. Processing time for an initial Form CMS-855A shall be the same as any other change. An initial logging and tracking (L & T) PECOS record is required for this change.

Pay To Changes

For those *enrolled providers* who request a change to *Section 4* "Pay To" address, we are requiring intermediaries to examine closely any request for *a "Pay To"* address change to ensure that the request is from the provider. For change of "Pay To" address, the intermediary must follow these procedures:

1. Check billing records to determine if the provider has billed the program within 3 months. If the provider has billed the program, continue with the next step. If the provider has had no billing activity within 3 months, contact Benefit Integrity/PSC to determine if there has been any suspicious *conduct.* The Benefit Integrity/PSC must verify that this is an appropriate change. If it is determined that this request appears to be legitimate, continue with the processing of the application under 2 below. Of course if the change appears to be suspicious, the Benefit Integrity/PSC will pursue as necessary. Anytime a provider *requesting a "Pay To" change* has *not billed for four consecutive quarters* it is required to verify that the *provider is still actually in existence. For a CMHC which has been deactivated, it is necessary to verify that the enrollment data on file is still valid.*

2. If the *enrolled provider* has completed Form CMS-855A *on file*, verify *Form CMS-855A change request* signature against the existing signature to make sure that they match. When the applicant requests a telephone number change in the practice location section with a change to the pay-to-address, call the number listed on the provider file first. If the number on record is still active, attempt to speak with the *authorized representative/delegated official* who requested the change to verify the validity of the change. If you receive a directory assistance message changing the old number to a new number, and that number matches the provider's request for change, accept that change and contact the provider at the new number. Inform the provider you are making sure that this is a legitimate request for change. If the provider cannot be reached or a telephone number change seems suspicious, annotate the file and contact Benefit Integrity/PSC. If the change appears to be legitimate, continue with the update.

3. If the *enrolled provider does not have* an entire Form CMS-855A *on file,* the contractor shall request that they complete an entire Form CMS-855A based on these changes. Verify and validate all the information provided. *If the provider has already established its EDI agreement, article of incorporations, billing agreements, etc., it is not necessary to obtain the attachments unless for some reason the contractors has reason to do so. Handle this Form CMS-855A as a change for processing time purposes. However, it is considered and handled as an initial application for PECOS purposes.*

Do Not Forward Initiative

The intermediary must follow the "Do Not Forward" initiative instructions as communicated in Transmittal A-02-012, CR 1970. These changes require Form CMS-855A be submitted reflecting a change to the 'Pay To" address (a complete Form CMS-855A if none is on file) and should not be processed based solely upon a letter from the enrolled entity requesting a change to the "Pay To" address. Note that the Do Not Forward initiative cannot be implemented for Fiscal Intermediary Standard System (FISS) users until a later date to be communicated by CMS.

Post Office Box Change Only

When an enrolled provider changes their "Pay To" address from a post office box to a previously identified primary practice location a complete Form CMS-855A is not required. This applies even if there is no Form CMS-855 on file. The change should be reported as a change on a Form CMS-855A. However, the intermediary should perform a Qualifier.net verification that the current "Pay To" address is still a valid address.

G. Location of Patient Records.

1. The applicant should report where records are kept for each practice location. If the records are kept at the practice location shown in Section 4A or 4C, the applicant can skip this section. However, indicate that address in the system if the system allows you to do so.

2. If the address is different than that of a practice location, the applicant must indicate where the records are stored. If applicant does not have a place where it stores records, issue a recommendation for denial; see §14.3., Denial 3. Records kept at a storage location must be indicated.

Post office boxes and drop boxes are not acceptable as the address where patient records are maintained. If any of the above information is incomplete, continue the application verification process and request additional information. (See §14.1, request for additional information.)

H. Comments

This section is used to capture any unique or unusual circumstances concerning the provider's practice location(s) or the method by which the provider renders health care services. You must determine that the information provided is legal and accurate.

10.5 - Ownership and Managing Control Information (Organization) – (Rev. 41, 05-23-03)

Section 5: Ownership and Managing Control Information (Organizations)

Before reviewing the specific instructions for each Particular data element in this section, we strongly recommend that you read the following explanation of the terms "Ownership" and "Managing Organizations."

"Ownership" and "Managing Organizations"

All organizations that have any of the following must be listed in Section 5B:

- 5 percent or more ownership (direct or indirect) of the enrolling provider,

- Managing control of the enrolling provider, or
- A Partnership interest in the provider, regardless of the percentage of ownership the Partner has.

NOTE: All Partners within a Partnership must be reported on the application. This applies to general and limited Partnerships. For instance, if a limited Partnership has several limited Partners and each of them only has a 1 percent interest in the entity, each limited Partner would have to be listed on the application, even though each owns less than 5 percent. The 5 percent ownership threshold primarily applies to corporations and other organizations that are not Partnerships.

Owning/Managing organizations are generally one of the following types:

- Corporations (including limited liability corporations and non-profit corporations);
- Partnerships/limited Partnerships (as indicated above);
- *Limited Liability Companies;*
- Charitable and Religious Organizations; or
- Government/Tribal Organizations.

NOTE: Any entity listed in Section 2B1 or 2B2 of this application need not be listed in this section. For instance, suppose "Jones Hospital" is set up as a corporation, with five stockholders each owning 20%. Assume further that Jones Hospital is listed in Section 2B1 as the legal business name of the company.
Under this scenario, Jones Hospital would not have to be listed in Section 5 because Jones is mentioned in Section 2B1 as the provider. In other words, Jones is the provider, not an owner or managing organization. Rather, the owners of Jones are the five stockholders. Thus, only the stockholders need to be reported as owners in Section 5 and/or 6 (depending on whether the stockholders are individuals or organizations.)

5 Percent Or More Ownership

All entities that own 5 percent or more of the enrolling provider must be listed on this form. Many enrolling providers may be owned by only one organization. For instance, suppose the enrolling provider is a home health agency that is wholly (100 percent) owned by Company A. The provider would have to list Company A in this section since the latter owns at least 5 percent of the provider. In addition, Company A is considered to be a direct owner of the provider in that it actually owns the assets of the business.

There are occasionally more complex ownership situations, however. Many organizations that directly own an enrolling provider are themselves wholly or Partly owned by other organizations (or even individuals). This is often the result of the use of holding companies and

parent/subsidiary relationships. Such organizations and individuals are considered to be "indirect" owners of the enrolling provider. Using our example in the previous paragraph, if Company B owned 100 percent of Company A, Company B would be considered an indirect owner - but an owner, nevertheless - of the provider. In other words, a direct owner has an actual ownership interest in the provider (e.g., owns stock in the business), whereas an indirect owner has an ownership interest in an organization that owns the provider. For purposes of this application, direct and indirect owners must be listed if they own at least 5 percent of the provider. The Form CMS-855A Instructions contain an example of how providers can and should determine who needs to be listed as an owner on this application.

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

1. 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

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

Refer to Example 2 of the Form CMS-855A Instructions for more information.

Managing Control (Organizations)

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

Special Types of Organizations and Situations

Governmental/Tribal Organizations--If a Federal, state, county, city or other level of government, or an Indian tribe, will be legally and financially responsible for Medicare payments received (including any potential overpayments), the name of that government or Indian tribe must be listed as an owner. The enrolling provider must submit a letter on the letterhead of the responsible government (e.g., government agency) or tribal organization, which attests that the government or tribal organization will be legally and financially responsible in the event that there is any outstanding debt owed to CMS. This letter must be signed by *the* "authorized official" of the government or tribal organization who has the authority to legally and financially bind the government or tribal organization to the laws, regulations, and program instructions of Medicare. See §10.15 of this manual for further information on "authorized officials."

Charitable and Religious Organizations--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 this section. 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 evidences its claim, such as written documentation from the State, etc. This documentation is necessary if the applicant does not list any owners (not just board members, directors, and/or managers) in Section 5 or Section 6 of the application. However, the contractor does not have to obtain the documentation, if as a result of the Qualifier.net review, they can determine that the enrolling entity is a non-profit charitable or religious organization.)

Ownership Transfer to a Family Member--If a sanctioned or excluded provider/supplier transfers its ownership interest to a family member, refer the case to BI unit. After its review, it should consult with the OIG to determine if the applicant/enrollee should be enrolled or terminated. If the OIG does not respond within 10 calendar days, any additional delay shall not count against the contractor for processing time purposes. However, this must be annotated in the file showing proof that OIG has the case.

A. Check Box

This box should be checked if there are no organizations with at least a 5 percent direct or indirect ownership interest in, Partnership interest in, and/or managing control over, the enrolling provider. If this box is not checked, the provider must furnish information on those entities that own or manage it, or have a Partnership interest in the provider.

B. Organization with Ownership and/or Managing Control--Identification Information

Check to see whether the provider is adding, deleting, or changing information on an existing organization. If one of these boxes is checked, make sure that an effective date is listed. If so, enter this information into the system. If not, continue processing the application and then request the effective date. Remember that organizations with a 5 percent or greater ownership interest in, any Partnership interest in, or managing control over the provider must be listed here in Section 5. No individuals should be listed in this section.

1. The provider should check whether it is furnishing information concerning 5 percent ownership, Partnership interest(s) and/or managing control. In addition, the provider must provide the effective date of such ownership or control. If the organization listed has a Partnership interest in the provider, the provider should furnish the effective date of ownership.

2. The legal business name of the organization(s) listed in this section must be provided. *This organization(s) does not have to routinely provide an IRS document to check against its TIN unless this organization has not been reported in section 2 of Form CMS-855A. Only the provider's legal business entity routinely needs to be checked against the IRS document. This means that the intermediary normally only has to obtain* ***one*** *IRS document regardless of how many owners, managers or directors that a provider's legal business entity has.*

3. Capture the "Doing Business As" name as reported. If none is listed, assume that the entity does not have a DBA name. The tax identification number must also be reported.

4. The business address of the owning/managing organization must be furnished.

C. Adverse Legal History

1. For each organization listed are this section (other than organizations with only managing control, as these organizations not required to complete this section), check the name and EIN or Medicare/Medicaid numbers against Qualifier.net (for MED and GSA data), FID (IF APPLICABLE) and HIPDB. The organization must be checked against the aforementioned databases regardless of whether the enrolling provider states in this section that the organization has never had an adverse legal action imposed against it. If the organization is excluded or debarred, recommend denial to the RO explaining the reason(s) for denial; see §14.3, Denial 1. If the provider indicates that the organization has had an adverse legal action imposed against it but Qualifier.net does not report this, contact the OIG and/or Benefit Integrity/PSC to determine whether this can and should form the basis of an exclusion. Hold (but continue processing) the application until the OIG decides whether the adverse legal action should result in an exclusion. If the OIG imposes an exclusion, recommend denial to the RO; see §14.3, Denial 1.

If the organization appears on the FID, process the application according to §16.1. If the organization appears in the HIPDB, process the application according to §16.2.

2. If the provider indicates that the organization has had an adverse legal action imposed against it, make sure that the provider furnishes information concerning the type and date of the action, and what court(s) and law enforcement authorities were involved. Also, documentation that evidences the imposition/notification and resolution of the adverse action must be submitted (e.g., notification of disciplinary action, criminal court documents). If the organization was excluded but has since been reinstated, verify this through the OIG and ask the applicant to submit written proof (e.g., reinstatement letter) indicating that such reinstatement has in fact taken place.

10.6 - Ownership and Managing Control Information (Individuals) – (Rev. 41, 05-23-03)

Section 6. Ownership and Managing Control Information (Individuals)

Before proceeding with the instructions for Section 6, review the explanation of the term "ownership" in Section 5. Although the explanation there refers to the applicant as the "enrolling provider," the definitions and explanations have the same applicability to individuals.

For purposes of this application, the terms "officer," "director," and "managing employee" are defined as follows:

- Officer--any person whose position is listed as being that of an officer in the provider's "Articles of Incorporation" or "Corporate Bylaws," OR anyone who is appointed by the board of directors as an officer in accordance with the provider's corporate bylaws.

- Director--a member of the provider's "Board of Directors." It does not include a person who may have the word "Director" in his/her job title (e.g., Departmental Director, Director of Operations). Note, however, that a person who has the word "Director" in his/her job title may be a "managing employee," as defined below. Moreover, where a provider has a governing body that does not use the term "Board of Directors," the members of that governing body will still be considered "Directors." Thus, if the provider has a governing body titled "Board of Trustees" (as opposed to "Board of Directors"), the individual trustees are considered "Directors" for Medicare enrollment purposes.

- Managing Employee--Any individual, including a general manager, business manager, or administrator, who exercises operational or managerial control over the provider, or who conducts the day-to-day operations of the provider. For Medicare enrollment purposes, "managing employee" also includes individuals who are not actual employees of the provider but *who*, either under contract or through some other arrangement, manage the day-to-day operations of the provider."

Use Qualifier.net to identify other individuals who may have this type of relationship with the applicant. If during a Particular search, a name appears that was not listed on the application, query that name against Qualifier.net (for MED and GSA data), the FID (IF APPLICABLE) and the HIPDB. If you find that this person was excluded or debarred, deny the application; see §14.3, denial 1. If found on the FID or HIPDB, process according to §16.1 and 16.2, respectively. If a name was found that was not otherwise reported, request additional information.

A. Individual with Ownership and/or Managing Control--Identification Information

Check to see whether the provider is adding, deleting, or changing information on an individual in this section. If one of these boxes is checked, make sure that an effective date *for the change* is listed. *If the boxes for Effective Date of Ownership or Effective Date of Control have not or cannot be completed, the application can still be processed without further discussion with the applicant. A potential, recommendation for approval or denial, can still be made. For PECOS entry the contractor can enter the date of the signature on the certification statement.* Remember that individuals must be listed here in Section 6. No organizations should be listed in this section.

B. Adverse Legal History

1. For each individual listed in this section, check the name and SSN or Medicare/Medicaid numbers against Qualifier.net (which contains MED and GSA data), FID (IF APPLICABLE) and HIPDB. The individual must be checked against the aforementioned database(s) regardless of whether the enrolling provider states in this section that the individual has never had an adverse legal action imposed against him/her. If the individual is excluded or debarred, recommend denial to the RO and explain the reason(s) for denial; see §14.3, Denial 1. If the provider indicates that the individual has had an adverse legal action imposed against him/her but Qualifier.net does not report this, contact the OIG and/or Benefit Integrity/PSC to determine whether this can and should form the basis of an exclusion. Hold the application until the OIG

decides whether the adverse legal action should result in an exclusion. If the OIG imposes an exclusion, recommend denial to the RO. If not, continue to process the application normally.

If the individual appears on the FID, process the application according to §16.1. If the individual appears in the HIPDB, process the application according to §16.2.

2. If the provider indicates that the individual has had an adverse legal action imposed against him/her, make sure that the provider furnishes information concerning the type and date of the action, and what court(s) and law enforcement authorities were involved. Also, documentation that evidences the imposition/notification and resolution of the adverse action must be submitted (e.g., notification of disciplinary action, criminal court documents). If the organization was excluded but has since been reinstated, verify this through the OIG and ask the provider to submit written proof (e.g., reinstatement letter) indicating that such reinstatement has in fact taken place.

10.7 - Chain Home Office Information – (Rev. 29, 07-26-02)

Section 7. Chain Home Office Information

All providers that are currently Part of a chain organization or who are joining a chain organization must complete this section with information about the chain home office. A chain organization exists when multiple providers/suppliers are owned, leased, or through any other devices, controlled by a single business entity. This entity is known as the chain home office. Generally, the chain home office maintains and controls:

- Uniform procedures in each facility for handling admissions, utilization review, and preparing and processing admission notices and bills; *and*

- Provider cost reports and fiscal records (i.e., a major Part of the Medicare audit for each component can be performed centrally).

The information provided in this section is used to ensure proper reimbursement when the provider's year-end cost report is filed with the FI. In addition, the data are necessary to avoid overpayments and/or other administrative actions or penalties.

A. Check Box

This box should be checked if this section does not apply to the applicant. If this box is not checked, the provider must furnish information pertaining to the chain home office.

B. Type of Action this Provider is Reporting

Check to see whether the provider is changing information concerning a chain home office. If the box is checked, make sure that an effective date is listed.

The applicant/provider must indicate the type of action it is reporting about its relationship to the chain organization. For initial enrollment, the applicant must complete the remainder of Section 7. If the provider is no longer associated with the chain organization currently reported, it need only complete Section 7D. If the provider has changed from one chain to another, it must complete the remainder of Section 7 with information about the NEW chain home office. If only the name of the chain home office is changing and all other information remains the same, the provider need only complete Section 7D.

The applicant/provider must also list the effective date of the change.

C. Chain Home Office Administrator Information

The applicant/provider must complete this section if it is enrolling for the first time or is Part of a new chain organization. The name, title (e.g., CEO, CFO, COB), SSN, and date of birth of the home office administrator must be submitted.

Check the administrator's name and SSN against Qualifier.net (for MED and GSA data), the FID (IF APPLICABLE) and the HIPDB. If the administrator is excluded or debarred from the Medicare program, continue processing the application and determine whether he/she is an owner, Partner, director, officer, or managing employee within the provider's organization. (This is accomplished by checking Section 6 of the applicant's Form CMS-855 or any existing files you have pertaining to the provider.) If the administrator is such a person, recommend denial to the RO. If not, you may continue to process the application as usual. If further assistance is needed, contact Benefit Integrity/PSC or the RO.

If the administrator appears on the FID or HIPDB, process the application according to §16.1 and 16.2 respectively.

If the provider is changing information about an existing administrator (e.g., new job title) or is changing administrators outright, the effective date of the change must be provided.

D. Chain Home Office Information

Check to see whether the provider is changing information concerning an existing chain home office (e.g., new address, new phone number, etc.). If the box is checked, make sure that an effective date is listed.

The applicant/provider must furnish the chain home office's name, tax identification number, business address (e.g., corporate headquarters), telephone number, chain number, home office intermediary, and the end date of the home office's cost reports. In addition, check the home office's name and TIN against Qualifier.net, the FID (IF APPLICABLE) and the HIPDB. If the home office is excluded or debarred from the Medicare program, continue processing the application and determine whether it is an owning or managing organization of the applicant/provider. (This is accomplished by checking Section 5 of the applicant's Form CMS-855 or any existing files you have pertaining to the provider.) If the home office is in fact an

owning or managing organization, recommend denial to the RO. If not, you may continue to process the application as usual.

If the applicant appears on the FID or HIPDB, process the application according to §16.1 and 16.2 respectively.

E. Type of Business Structure of the Chain Home Office

Check to see whether the provider is changing information concerning the business structure of the existing chain home office (e.g., changing its business structure from a Partnership to a corporation, etc.). If the box is checked, make sure that an effective date is listed.

F. Provider's Affiliation to the Chain Home Office

Check to see whether the provider is changing information concerning its affiliation with the chain home office. If the box is checked, make sure that an effective date is listed.

10.8 - Billing Agency – (Rev. 41, 05-23-03)

Section 8. Billing Agency

A. Check Box

If the applicant indicates that its does not use a billing agent, indicate this in the system. If the applicant fails to check the box, request additional information; see §14.1.

B. Billing Agency Name and Address

1. Indicate the business name and tax identification number of the billing agency in the system. Query this name against Qualifier.net (for MED and GSA data), FID (IF APPLICABLE) and HIPDB databases . You cannot use any other validation source to do this search. If you find a match, refer this application to Benefit Integrity/PSC.

2. List the "Doing Business Name" if applicable.

3. Maintain the business street address.

C. Billing Agreement/Contract Information

If the applicant indicates that he/she is using a billing agency, the applicant must answer all the questions concerning its agreement. If you wish to verify/validate information you may request a copy of the billing agency agreement. The FI must review at least one billing agency agreement every six months (except if none is available). All agreements must meet the requirements in MIM §3488 through §3488.4. In cases where violations are discovered, the provider must be notified that it is in violation of the law.

The following outcomes should be applied consistent to the answer.

1. Annotate who is coding the bills--either the billing agent or applicant.

2. If the applicant indicates that he/she does not have unrestricted access to its Medicare remittance notice, contact the applicant orally or in writing to inform him/her of their responsibilities for the bills submitted in their name.

3. If the applicant indicates that Medicare payment is going directly to it, verify that this corresponds with the pay-to-address on the application. If the pay-to-address is a post office box, verify with the applicant that it has ownership of the post office box. If payment is going directly to the bank, verify that the account is only in the name of the applicant and meets MIM §3488. If found that the above is not true, request the applicant to answer question 3 "No" and to answer questions 4, 5, and 6 appropriately and inform the applicant that it must abide by requirements in MIM 3488. The verification site above can be oral or in writing.

4. If the applicant indicates that Medicare payment is going directly to the bank, verify that this corresponds with the pay-to-address on Form CMS-855A. Make sure that the answers to questions to a), b), and c) are yes. If found that the applicant is incorrect, request the applicant to answer question "No" and to answer questions 5 and 6 appropriately and inform the applicant that it must abide by requirements in MIM 3488. If the applicant indicates, "No" go to question 5.

5. If Medicare payment is going directly to the billing agent, make sure that the applicant answers questions in 5. If the billing agent cashes the check, make sure that the applicant indicates "Yes" for the 5 conditions, which are met in accordance with MIM 3488. If the applicant responds "NO' the billing agency does not cash the check, make sure that it responds to 5b. If in 5b it checks "NO," request the billing agreement to determine where payment is going. If the applicant answers "No" that Medicare payment does not go to the billing agent, verify that the applicant answers question 6.

6. Verify that the information submitted corresponds to the information in the pay-to-address. If it does not, follow-up with the applicant with their pay-to-address information. In reviewing the answer to the questions, if any inconsistencies are found or any reason to believe that the information is not correct, request a copy of the billing agreement. This is the contractor's discretion and is not negotiable with the applicant. The contractor does not have to have specific information to justify the request of a billing agreement. This request is solely a decision based on the review of Form CMS-855A or any other group affiliation that is associated with this enrollment. If an applicant does not correct its billing agreement, notify the applicant that its billing arrangement violates Medicare policy. If the applicant fails to come into compliance, follow the instructions in MIM 3488.

10.9 - Electronic Claims Submission Information - (Rev. 41, 05-23-03)

If the applicant indicates that he/she intends to file claims electronically, the applicant must submit a copy of his/her current EDI agreement with this application. *If, however, an EDI agreement is submitted after enrollment, the provider enrollment unit does not have to complete or maintain this information.*

A. Check Box

Continue to process the application if this box is checked. If none of the boxes are checked, and this information is blank, assume that this section does not apply.

B. Check Box

If this box is checked, provide the applicant information on how to submit his/her claims electronically.

C. First Clearinghouse Name and Address

1. Legal Business Name and Tax identification Number - If the entity does not disclose its TIN, it can use its submitter number. If any of the information is missing or incomplete, do not request additional information. Continue to process the application.

2. Annotate the "Doing Business As" (DBA) name.

3. List the street address of the entity in the system.

D-E. These sections allow the applicant the ability to report on more than one clearinghouse.

10.10 - Staffing Company – (Rev. 29, 07-26-02)

Section 10. Staffing Company

NOTE: If the FI's system cannot enter this data, just review the data.

This section is to capture information about the staffing companies the provider uses or contracts with either under written contract or by an unwritten agreement.

A. Check Box

Determine if the applicant has appropriately checked the box as required.

B. Staffing Company Name and Address

Note the legal business name, DBA name (if applicable) and tax identification number of the staffing company in the system. Query this name against Qualifier.net (for MED and GSA data), FID and HIPDB databases. If you find a match, refer this application to Benefit Integrity/PSC. Also query the system to determine who else may be using this staffing company and provide that information to Benefit Integrity/PSC.

C. Staffing Company Contract/agreement information

Enter the departments that the company staffs.

10.11 - Surety Bond Information - (Rev. 29, 07-26-02)

Section 11. Surety Bond Information

This section is to be completed by providers who are mandated by law to obtain a surety bond in order to enroll in and bill the Medicare program.

10.12 - Capitalization Requirements for Home Health Agencies (HHAs) – (Rev. 29, 07-26-02)

Section 12. Capitalization Requirements For Home Health Agencies (HHAs)

If the applicant is a home health agency it must meet the capitalization requirements for enrollment purposes. Please verify that the home health agency has provided documentation supporting that it has sufficient initial reserve operating funds (capitalization) to operate for the first three months of operation in the program(s). If this information is completed and has been submitted to the wrong intermediary, forward to the appropriate Party responsible for verifying this information.

The RHHI/intermediary shall promptly contact the RO (via letter, fax, E-mail or telephone calls) if guidance is needed when computing the capitalization requirements for HHAs.
The RHHI/intermediary shall document the date that the RO was notified and the date that the response was received. If the RO does not respond to the RHHI/intermediary's request within 10 calendar days, then the delay in application processing time that this causes shall be considered an excusable delay.

However, if the capitalization has not been met, issue a recommendation that the application be denied.

10.13 - Contact Person – (Rev. 29, 07-26-02)

Section 13. Contact Person

This is the person to call if there are any questions regarding the information furnished in the application. If the applicant does not provide a contact person, call the individual who signed the application for any questions that need clarification. If additional information is needed, send it to the attention of the contact person.

10.14 - Penalties for Falsifying Information - (Rev. 29, 07-26-02)

Section 14. Penalties For Falsifying Information on This Enrollment Application

This section lists various criminal and civil penalties that can be imposed against a Medicare provider or supplier (or an applicant for enrollment in the Medicare program) for fraudulent activity. Familiarize yourself with this section, as doing so will enhance the ability to spot potential fraud and abuse.

10.15 - Certification Statement – (Rev. 41, 05-23-03)

Section 15. Certification Statement

A. Additional Requirements for Medicare Enrollment

The Certification Statement contains certain requirements that must be met in order for the provider to be enrolled in the Medicare program. By their signature(s), the authorized official and delegated official(s) bind the provider to all of the requirements listed in the Certification Statement and acknowledge that the provider may be denied entry to or revoked from the Medicare program if any requirements are not met or maintained.

B. Authorized Official Signature

For initial enrollment, the Certification Statement must be signed and dated by the authorized official of the provider. An authorized official is defined as an appointed official to whom the provider has granted the legal authority to enroll it in the Medicare program, to make changes and/or updates to the provider's status in the Medicare program (e.g., new practice locations, change of address), and to commit the provider to fully abide by the laws, regulations, and program instructions of Medicare. The authorized official must be the provider's general Partner, chairman of the board, chief financial officer, chief executive officer, or president, or must hold a position of similar status and authority within the provider's organization. The authorized official can also be a person who is a direct owner of 5 percent or more of the enrolling provider. (See § 10.5 of this manual for the definition of a direct owner). The provider may only have one authorized official at any given time. In addition to meeting the requirements listed in this paragraph, the authorized official must be listed in Section 6 of Form CMS-855A.

If the contractor is fairly certain that the authorized official signing the application has the authority to bind the organization (e.g., signatory is a CEO, president, or - if the applicant is a governmental entity - head of the County Health Department), continue processing the application. Should the contractor have doubts about the authorized official's authority, contact the authorized official or the applicant's contact person to obtain more information about the official's job title and/or authority to bind. If you remain unconvinced about the official's

authority to bind the applicant, request that someone else within the organization (e.g., CFO, chairman of the board, etc.) sign the application. If the provider refuses, deny the application.

*In accordance with Section25 of these instructions, d*ocument any contact with the authorized official, contact person, or other provider official when investigating whether the authorized official has the power to bind.

Only the authorized official has the authority to sign the initial Form CMS-855 application on behalf of the provider. The delegated official has no such authority.

The signature of the authorized official must be original. Faxed, stamped, or photocopied signatures cannot be accepted. Check whether the provider is changing the authorized official currently on file and make sure that an effective date is listed. In order to change authorized officials, the provider must:

1. Check the "Delete" box in Section 15B and provide the effective date of the deletion. In addition, the authorized official being deleted must provide his or her printed name, signature, and date of signature. Since you already have that official's job title, SSN, date of birth, and Medicare identification number on file, he/she need not supply this information again.

NOTE: If the deleted authorized official failed to provide his/her signature, contact the provider to find out why. If you become convinced that obtaining this signature would pose an undue burden on the provider (e.g., the deleted authorized official was terminated or has left the company), you may forgo the signature requirement. Remind the provider over the telephone that the deleted authorized official no longer has the authority to sign the Form CMS-855A on behalf of the provider. Document that this reminder was given as well as the reason(s) why the signature of the deleted authorized official was unattainable.

2. Submit a copy of the page containing the Certification Statement, check the "Add" box in Section 15B and provide the effective date of the addition. Also, the new authorized official must provide the information requested in 15B, along with his/her signature and date of signature. When changing authorized officials, the new authorized official assumes from the prior authorized official all of the powers (e.g., the power to delegate authority to a delegated official) previously held by the latter, and also agrees to adhere to all of the requirements (including those outlined in Section 15B) listed in the Certification Statement. However, a change in authorized officials has no bearing on the authority of existing delegated officials to make changes and/or updates to the provider's status in the Medicare program.

If the new authorized official is not currently listed in the contractor's records and is not disclosed in Section 6, request that the new official complete Section 6.

If the provider is submitting a change of information (e.g., new practice location, change of address, new Part-owner) and the authorized official listed on the form is different from the

official you currently have on file, secure the signature of the latter person or the signature of a delegated official already on file. If the provider wants or needs a new authorized official, it must follow the procedures outlined above.

If the provider is changing information about an existing authorized official (e.g., change in job title), it must check the "Change" box and provide the effective date, along with the changed data. The authorized official must then sign and date the form.

10.16 - Delegated Official – (Rev. 41, 05-23-03)

Section 16. Delegated Official (Optional)

A delegated official is either: (1) a managing employee of the provider, or (2) holds a 5 percent direct ownership interest, or any Partnership interest in the provider. This individual must have been delegated the legal authority by the authorized official listed in Section 15B to make changes and/or updates to the provider's status in the Medicare program, and to commit the provider to fully abide by the laws, regulations, and program instructions of Medicare.

For purposes of Section 16 only, the term "managing employee" means any individual, including a general manager, business manager, or administrator, who exercises operational or managerial control over the provider, or who conducts the day-to-day operations of the provider. This does not include persons who, either under contract or through some other arrangement, manage the day-to-day operations of the provider but who are not actual *W-2* employees. For instance, suppose Joe Smith is hired as an independent contractor by the provider to run its day-to-day-operations. Under the definition of "managing employee" for Section 6 (Ownership and Managing Control (Individuals)), Smith would have to be listed. However, under the Section 16 definition (as described above), Smith cannot be a delegated official because he is not an actual W-2 employee of the provider. Independent contractors are not considered "managing employees" under Section 16. In addition to meeting the requirements listed in this paragraph, the delegated official must be listed in Section 6 of Form CMS-855A.

A. Check Box

If the provider chooses not to appoint a delegated official, it should check the box in this section. There is no requirement that the provider have a delegated official. Should no delegated officials be listed, however, the authorized official remains the only individual who can make changes and/or updates to the provider's status in the Medicare program.

B. Delegated Official Signature

1. If the provider chooses to add a delegated official OR to delete an existing one, the delegated official being added must provide all of the information requested in this section, including his/her signature and date thereof. If the delegated official is being deleted, he/she need only provide his/her name. A signature is not required. In both cases, the authorized official currently on record must provide his/her signature and date in Sections 15B and 16B2. The signature of the

authorized official in Section 16B2 constitutes a legal delegation of authority to any and all delegated official(s) listed in Section 16.

If the delegated official is a W-2 employee, it should check the appropriate box in 16B1. If this box is not checked and it does not appear that the delegated official is a Partner or a 5% owner (e.g., the delegated official is not listed in Section 6), verify the capacity in which this individual is acting as a delegated official.

Only the authorized official has the authority to sign the initial Form CMS-855 application on behalf of the provider. The delegated official has no such authority. However, once a delegated official has been designated, he/she may make any changes and/or updates to the provider's status in the Medicare program. The authorized official, nevertheless, still retains the authority to make changes to the Form CMS-855, if he/she chooses to do so.

When making changes and/or updates to the provider's enrollment status, the delegated official should sign Section 15B. However, if the delegated official signs Section 16B1 instead, accept the signature and continue processing the application.

If the provider is changing a delegated official, it must:

- Check the "Delete" box and provide the effective date of the deletion. Only the deleted delegated official's name need be provided. A signature is not necessary. In addition, since the file has that official's job title, SSN, date of birth, and Medicare identification number on file, he/she need not supply this information again; and

- Submit a copy of the page containing Section 16, check the "Add" box, and provide the effective date of the addition. The new delegated official must complete this section in full. In addition, the authorized official currently on record must provide his/her signature and date in Sections 15B and 16B2. *If the new official is not currently listed in the contractor's records and is not disclosed in Section 6, request that the new official complete Section 6.*

If the provider is changing information about an existing delegated official (e.g., change in job title), it must check the "Change" box and provide the effective date, along with the changed data. The authorized official must then sign and date the form in Section 15B. (Section 16B2 need not be completed.)

If the provider is submitting a general change of information (e.g., new practice location, change of address, new Part-owner) and the delegated official listed on the change is different from the official(s) on file, *send a copy of the application (but only those pages that were completed as part of the change request) along with a blank certification statement to the provider for the proper signature.* If the provider wants a new delegated official, it must follow the procedures outlined above. A provider can have no more than three delegated officials at any given time.

The changes and/or updates that may be made by the delegated official include situations where the provider is contacted by the contractor in order to clarify or obtain information needed to continue processing the provider's initial Form CMS-855 application.

Delegated officials may not delegate their authority to any other individual. Only an authorized official may delegate the authority to make changes and/or updates to the provider's Medicare status.

10.17 – Special Processing Situations – Rev. 41, 05-23-03)

Conversions of an enrolled hospital to become a Critical Access Hospital (CAH) or other specialty Hospital. The following is the procedure to be used to effect subject conversion.

1) *Do not ask for a new initial Form CMS-855A. Handle the request as a change of information.*

2) *Advise the applicant to fill out only the following in Form CMS-855A.*

   a. *On page 7, in 1.A.1 check the Change of Information block, also fill in the information for items 2 and 3 for the Tax Identification Number and the Medicare Identification Number.*

   b. *On page 15, in block 2.A.2 check the Change block, fill in the effective date and check Hospital—Critical Access.*

   c. *On Page 51, in block 15B fill in the entire block.*

   d. *On page 35, in 6.A.1 fill in only the name, SSN, date of birth and credentials for the individual who is listed in the certification statement (block 15.B.).*

3) *Review the individual listed in block 6.A.1 against all required databases.*

4) *Check to determine that the hospital qualifies for the CAH status by contacting the state agency or by obtaining the license.*

5) *Make the change and notify the applicant, the RO, and the state agency.*

6) *The change should be performed in 45 days in accordance with the timeliness guidelines for all changes.*

Rural Health Clinic (RHC) Enrollment – Upon completion of Form CMS-855A processing of an RHC enrollment, the intermediary should forward a copy of Form CMS-855A and the recommendation to the cognizant carrier for the area where the RHC is located. Provide a note stating that this is for information only. This will alert the carrier to be cautious about the possibility of double billing between a carrier enrolled group that is also enrolled as an RHC with the intermediary.

Receivership – If an enrolled provider enters bankruptcy receivership, they are not required to submit a new Form CMS-855A unless they are sold.

11 - Community Mental Health Centers (CMHCs)--(Rev. 7, 05-31-01)

11.1 - Benefit Improvement and Protection Act (BIPA) of 2000 Provisions –

Section 431 of BIPA amended Section 1861(ff)(3)(B) of the Act concerning the qualifications that must be met by some CMHCs to Participate in the Medicare program. As a result of this legislative change which became effective March 1, 2001, a CMHC that is precluded by state law from providing the core service related to screening described in Section 1913(c)(1)(E) of the Public Health Service Act (PHSA) must provide the screening under a contract with an approved organization or entity that is determined to be acceptable by CMS on behalf of the Secretary. Consequently, in the case of a CMHC applicant operating in a state that by law precludes the CMHC from providing the preadmission screening, the FI is no longer required to contact the CMS RO to make this legal capacity determination.

The CMS RO, on behalf of the Secretary, may approve an entity or organization as a contractor for the purpose of the BIPA screening provision if the organization or entity's contract with the CMHC meets prescribed contract terms. CMS will not grant a "blanket approval" for an entity or organization to conduct screening under a contract with a CMHC, but instead, must review each contract to ensure that it meets the prescribed contract terms. A contractor may contract with more than one CMHC to provide screening, and a CMHC may contract with more than one entity or organization to provide screening.

CMS itself must determine if~~s~~ the screening is with an approved organization or entity. The CMHC must maintain documentary evidence that screening occurred in a Particular case and provide a copy of the contract for screening to CMS upon request.

11.2 - CMHC Enrollment and Change of Ownership Site Visit Process – (Rev. 41, 05-23-03)

After January 15, 2002, CMS will no longer have a contract with Integriguard (National CMHC Site Visit Contractor) to conduct site visits of CMHCs for any reason. Therefore, after January 15, 2002, the FI will continue to verify enrollment information on Form CMS-855A forms submitted by CMHCs seeking initial enrollment or undergoing Changes of Ownership (CHOWs). However, until further notice, once the FI has completed their review and recommended that the enrollment application or that the CHOW be approved, the FIs will forward any request for a site visit to the appropriate CMS RO (RO), Division of Medicaid and State Operations (DMSO).

Upon receipt of a request for a site review, the RO will perform the site review with the emphasis of the visit focused on whether the CMHC meets or continues to meet the core service requirements.

For Initial CMHC Enrollments

Follow the contractor's current procedures for provider enrollment, including communicating and sharing information with the state agencies (SA) (or for FIs in RO IX, the contractor's RO) regarding enrollment up to and including verification of the Form CMS- 855A. If the Form CMS-855A cannot be verified, follow procedures for recommending denial of enrollment.

In addition to the contractor's current procedures, check for a completed and signed CMHC attestation statement from the SA (or for FIs in RO IX, the contractor's RO). If the CMHC has not filed a completed attestation statement with the SA (or for FIs in RO IX, the contractor's RO), follow current procedures for recommending denial, and file a recommendation for denial.

If the Form CMS-855A has been verified, and the CMHC has filed a completed attestation statement, send a copy of the Form CMS-855A back to the SA (or for FIs in RO IX, the contractor's RO) for retention, and issue the contractor's recommendation for approval. Using ***Attachment B****,* ***"Community Mental Health Center Site Visit Request Form,"*** *contact the appropriate CMS RO, DMSO via e-mail to initiate a site visit of the CMHC applicant. Send a copy of the request to the SA, and the appropriate RO provider enrollment contact.*

Once the site visit is completed, the RO DMSO will contact you via the provider agreement tie-in notice to inform you of the outcome of the site visit review process and the effective date of Medicare Participation, if applicable.

Site Visits to Existing Medicare CMHCs

There may be instances, such as a CMHC audit, which may prompt the RO DMSO to conduct a site visit of an existing CMHC. The RO DMSO may contact you prior to the site visit for information about the CMHC, including:

- *Significant cost report audit information;*
- *Significant medical review information;*
- *Significant fraud information;*
- *CMS Customer Information System (HCIS) data from the two most recent completed data years on the CMHC to be visited; and*
- *Any information regarding overpayments from the overpayments database.*

In instances where a site visit is completed for an existing CMHC that does not have a Form CMS- 855A on file, send the Form CMS-855A to the CMHC and request that it be completed. Direct all calls and correspondence regarding the CMHC site visit process to the appropriate RO DMSO address.

CHOWs Without Assignment

If the CMHC buyer does not or will not be accepting assignment, the CMHC seller must submit the Form CMS-855A to apprise you of the CHOW as soon as possible. The CMHC buyer should submit a new Form CMS-855A and be treated as an initial applicant.

*Before initiating a site visit, check to ensure that the CMHC has not changed its address. If the CMHC has changed its address, notify the RO in writing. Use **Attachment A**, **"Community Mental Health Center Notification and Approval of Address Change,"** to do so. Continue to process the application according to established time frames. If the RO DMSO does not approve the change of address, recommend a denial and file a recommendation for denial citing the reason.*

CHOWs With Assignment

If the CMHC owners are or will be accepting assignment, the following should be done:

- *The CMHC seller must submit the Form CMS-855A to apprise CMS of the CHOW as soon as possible. The CMHC buyer must also submit the Form CMS-855A;*

- *Once the Form CMS-855A is received from the buyer applicant, verify and process the Form CMS-855A in accordance with current procedures; and*

- *If the Form CMS-855A cannot be verified, follow current procedures for issuing a Recommendation for Denial.*

Check for a completed and signed CMHC attestation statement from the SA (or for FIs in RO IX, the contractor's RO). If the CMHC buyer applicant has not filed a completed attestation statement with the SA (or for FIs in RO IX, the contractor's RO), file a recommendation for denial, citing the reason.

*Check to ensure that the CMHC has not changed its address. If the CMHC has changed its address, notify the RO in writing. Use **Attachment A**, to do so. Continue to process the application according to established time frames. If the RO DMSO does not approve the change of address, file a recommendation for denial, citing the reason.*

If the Form CMS-855A is verified, the CMHC buyer applicant has filed a completed attestation statement, and has not changed its address, send a copy of the Form CMS-855A back to the SA (or for FIs in RO IX, the contractor's RO) for retention, and issue the recommendation for approval.

*Three months after the Form CMS-855A verification, or sooner if the CMHC buyer applicant is suspect but enrollment cannot be denied based solely on the information provided on the Form CMS- 855A, using **Attachment B**, contact the RO DMSO via e-mail to initiate a site visit of the CMHC. Send a copy of the request to the SA (or for FIs in RO IX, the contractor's RO), and the appropriate RO provider enrollment contact. The RO DMSO may contact the FI prior to the site visit for information about the CMHC prior to and after the CHOW, including:*

- *Any significant cost report audit information;*
- *Any significant medical review information;*
- *Any significant fraud information;*
- *HCIS data from the two most recent completed data years on the CMHC to be visited; and*
- *Any information regarding overpayments from the overpayments database.*

Provide this information upon request or as soon as possible. Provide this information with the request for the site visit. Direct all calls and correspondence regarding the CMHC site visit process to the appropriate RO DMSO address.

Once the site visit has been completed, the RO DMSO will contact the contractor with the outcome of the site visit review process. In addition, the RO DMSO may determine that the results of the site visit warrant action such as payment suspension.

ATTACHMENT A

COMMUNITY MENTAL HEALTH CENTER NOTIFICATION AND APPROVAL OF ADDRESS CHANGE

Date_____

Dear CMS RO, Division of Medicaid and State Operations:

In processing the following Medicare Community Mental Health Center (CMHC)'s CHOW application, it was discovered that the CMHC applicant buyer has undergone a change in address. In order to complete the enrollment process, it is necessary for the FI to verify with you in writing that the CMHC applicant will still be serving the same community it served before the address change. Please complete the Regional Office (RO) Division of Medicaid and State Operations (DMSO) portion of this form and return it to the FI contact person at the address, fax number, or e-mail address listed below within 14 days. Thank you.

The following information has been reported by the CMHC applicant on the Form CMS-855A:

FI completes the following for the CMHC applicant:

Doing Business as Name:_____
Legal Name:_____
Current Address:_____
Previous Address:_____
Current Phone Number:_____
Previous Phone Number:_____

Owner(s) Name: _____
Managing Employee: _____
Contact Person: _____
CHOW Date: _____

FI completes the following for the FI:

FI Name: _____
Address: _____
Phone Number: _____
Fax Number: _____

Regional Office, Division of Medicaid and State Operations completes the following:

Date: _____
The address change reported for the CMHC applicant noted above (check one):
_____ ***HAS BEEN approved.***
OR
_____ ***HAS NOT been approved.***

RO DMSO Contact Person: _____
Phone Number: _____
Fax Number: _____
E-mail Address: _____

ATTACHMENT B

COMMUNITY MENTAL HEALTH CENTER SITE VISIT REQUEST FORM

Date of Request: _____
Check Type of Site Visit:
___ *Initial Applicant*
___ *Change of Ownership with Assignment*
___ *Change of Ownership without Assignment*
___ *Other - (explain reason for visit)* _____

Please complete the following for the CMHC applicant requiring a site visit:
Name: _____
Address: _____
Phone Number: _____
Owner(s) Name: _____
Managing/Directing Employee: _____
Contact Person: _____

Please complete the following for the FI:
Name: _____
Address: _____

Phone Number: _____
Fax Number: _____
E-mail Address: _____
Contact Person: _____
Corresponding CMS RO: _____
CMS RO Contact: _____

11.3 - Deactivation of Billing Numbers for Inactive CMHCs – (Rev. 29, 07-26-02)

The purpose of the following instruction is to know when to deactivate the Medicare billing number of inactive CMHCs and how to notify inactive CMHCs about billing number deactivation. Deactivation occurs when a CMHC's provider agreement remains in effect but the FI has suspended payment to the CMHC until the FI receives and verifies the CMHC's updated Form CMS-855A information. This instruction also explains how inactive Medicare CMHCs may reactivate their billing numbers.

When a CMHC does not bill for a significant length of time, CMS and its FIs are unable to ensure that the data provided by the CMHC applicant at the time of enrollment are current. This inability to ensure correct provider data creates vulnerabilities for fraudulent and inappropriate use of the inactive billing number. Furthermore, FIs incur unnecessary costs to retain the enrollment and billing information of inactive CMHCs.

A CMHC that has not billed in 12 months is an inactive Medicare provider. Manually ascertain which CMHCs are currently inactive and determine if the CMHCs have been terminated or are undergoing termination procedures from the Medicare program. Establish a procedure to manually detect inactive CMHCs every six months thereafter. Deactivate the billing numbers of all inactive CMHCs that have not been terminated or are not undergoing termination and provide notice to the CMHCs that deactivation has occurred or will occur using the stock language provided in the attached deactivation letter. Notify the appropriate CMS RO of the deactivation by sending a copy of the attached letter. Also, notify Audit, Medical Review and Benefit Integrity/PSC about the deactivation action.

To resume status as an active Medicare CMHC provider, the inactive CMHC must update as necessary completely its current (or complete a new enrollment application if there is not one already on file) Form CMS-855A. To avoid incurring unnecessary costs for retaining inactive providers and billing number reactivation, Form CMS-855A should be submitted concurrently or after the CMHC resumes service to Medicare beneficiaries and bills for services rendered on their behalf. Any claims incurred before the reactivation of the CMHC billing number can be paid by the FI retroactively within the standard time limits for filing claims as specified in 42 CFR 424.44. Notify the appropriate CMS RO when a CMHC resumes status as an active Medicare provider.

Following notification of the FI's intent to deactivate the inactive CMHC's billing number, the CMHC may elect to voluntarily terminate its Participation in the Medicare program. In order to

voluntarily terminate its provider agreement, the CMHC must submit Form CMS-855A, completing Section 1A1 with the effective date of the termination, Section 1A3 with its Medicare identification number, and signing the Certification Statement in Section 15. Upon receipt of Form CMS-855A requesting voluntary termination, acknowledge the request, deactivate the requesting CMHC's billing number and refer the voluntary termination request to the appropriate CMS RO. Notify the appropriate state licensing and/or Survey and Certification Agency as well.

Stock Language--Provider Billing Number Deactivation Letter

Community Mental Health Center

CMHC Address:

Dear Sir or Madam:

The FI acting on behalf of the Centers for Medicare & Medicaid Services (CMS to process and pay your Medicare claims, has observed that in the past 12 months no claims have been submitted under your Community Mental Health Center (CMHC) Medicare billing number, (insert billing number). Due to lack of activity, CMS will deactivate your billing number, as of (add date of deactivation), rendering your CMHC an inactive Medicare provider. Deactivation occurs when a CMHC's provider agreement remains in effect but the FI has suspended payment to the CMHC until the FI has received and verified the CMHC's updated Form CMS-855A information.

You may wish to resume your CMHC's status as an active Medicare CMHC provider. However, to ensure that current data are on file, it will be necessary for you to complete an enrollment application, Form CMS-855A if you have never done so, or completely update your current Form CMS-855A when the CMHC resumes service to Medicare beneficiaries and bills for services rendered on their behalf. Any claims incurred before the reactivation of the CMHC billing number can be paid by the FI retroactively within the standard time limits for filing claims as specified in 42 CFR 424.44. You may obtain Form CMS-855A from your FI.

If you will no longer be submitting claims to the Medicare program, you may elect to voluntarily terminate your Medicare provider agreement. In order to voluntarily terminate your provider agreement, you must submit Form CMS-855A to the FI (insert FI address), completing Section 1A1 with the effective date of the termination, Section 1A3 with your Medicare identification number, and sign the "Certification Statement" in Section 15.

If you have any questions regarding this letter, please contact (insert name and phone number of FI contact).
FI Provider Enrollment Manager
cc: CMS RO

12 - State Survey/RO Process – (Rev. 41, 05-23-03)

Distribution of the new Form CMS-855A

Effective upon notification by CMS, intermediaries will distribute all Form CMS-855s for the providers they enroll. This is for the successor version of the January 1998 form. This is a change from the previous policy.

You will answer all applicant inquiries concerning enrollment. If the applicant contacts you prior to Form CMS-855A submission, advise the applicant that they are also required to contact the applicable State Agency or RO, as applicable. Document this. *Within 15 calendar days of your receipt of the Form CMS-855A send only a form letter (not the entire CMS-855A) to only the applicable state agency, or the RO if there is no state agency involvement. The form letter should cite,*

a) Legal business name of applicant,

b) Tax identification number,

c) Medicare identification number (if applicable),

d) The type of action requested,

e) Provider type,

f) Practice location addresses,

g) Contact person name and telephone number and

h) Any relevant information the intermediary thinks the state agency or RO needs prior to a final recommendation from the intermediary. This information should be obtained from the relevant sections of Form CMS-855A. For Changes of Information, the practice location address and contact person's name and phone number are not required unless these are being changed or are readily obtainable from the new or a previously filed Form CMS-855. For a CHOW, acquisition/merger, or consolidation, cite who the application is from (i.e., old owner, new owner, acquiring provider etc.) and include a copy of the sales agreement if received. The form letter can be submitted to the state agency or RO via e-mail if the receiving entity agrees to this method.

If the FI receives a Form CMS-855A from a state agency (a mistake unless it was a past version of the Form CMS-855) review the application to determine if it has an original signed certification statement. If it does, then process the application. If it doesn't, promptly contact the applicant to obtain an original signed copy. Then review the signed copy.

Information on Form CMS-855 is still considered valid (even if outdated) if caused by a delay in state agency surveys. If the application is over 6 months old due to provider delays, then the applicant must update the 855A (as applicable) *or just resubmit the current Form CMS-855A (as applicable) and sign a new certification statement. This information should be transmitted by the intermediary to the state agency and RO. The intermediary can assume that an update/resubmission of Form CMS-855A is not required, even if the application takes more than*

6 months from the time of submission until the applicant has passed a state survey or obtained accreditation. Only request an updated or resubmitted Form CMS-855A if informed by the state agency or RO that the delay was caused by the applicant. Any updated information should be validated. Resubmitted information does not require revalidation. An HHA applicant should be asked to resubmit capitalization requirements as part of this update/resubmission process.

13 - Changes of Information-New Form CMS-855 Data – (Rev. 41, 05-23-03)

Anytime a provider or supplier is adding, deleting, or changing information under the same tax identification number, it must report this change using the appropriate Form CMS-855. The applicant should check the changed section on the application in Section 1A1 and identify itself. Only the reported changes need to be completed on the application. For example, if an applicant is changing its correspondence address and a contact person is not listed, assume that the contact person is the same person as identified in the initial enrollment. Do not require the applicant to provide a new one. However, with any written change, always require that the certification statement in Section 15 be signed and dated. All signed certification statements must be kept -in-house (either photo imaged or original) to verify the signatures against the original Form CMS-855. *The initial application's certification statement is a verification tool and must be checked with any change request. If the contractor has any reason to question the validity of the certification statement, alert your Benefit Integrity/PSC for further action.*

Previously we allowed certain changes to be communicated by letterhead. This practice is no longer acceptable. All changes must be provided on the appropriate Form CMS-855.

Enrolled providers/suppliers who do not have an application on file can make a change (except for "Pay To" changes) by submitting just the changed item on an application. Do not request a complete Form CMS-855. Do not request enough information to form a skeletal record for PECOS. They should complete the following.

1. *Check the Change of Information block on item 1A1 of the application and fill in information for items 2 and 3 for the Tax identification Number and the Medicare Identification Number.*

2. *Make the applicable requested change in only the applicable section of the form.*

3. *Complete the entire block 15.B of the form.*

4. *In 6.A.1 complete only the name, social security number, date of birth and credentials for the individual who is listed in the certification statement (block 15.B.).*

The contractor shall check the individual listed in block 6.A.1 against all required databases and make a record that this was performed in the enrollment file. We understand that it is not possible to compare signatures since the enrolled provider/supplier does not have an application on file. Therefore, the only required check should be that of the appropriate databases. If the contractor has enough information from the Change of Information, Form CMS-855 and information it has on file then a skeletal record in PECOS should be made. Otherwise the change action should just receive a logging and tracking action in PECOS.

The contractor shall basically use the above guidance for enrolled providers and suppliers who have a Form CMS-855 on file. However, block 6.A.1 of the Form CMS-855 does not require completion. The contractor will just check the signature in block 15 or 16 against the corresponding signature in the Form CMS-855 on file.

If contacted by a group who states that it is voluntarily terminating its billing number, make sure that the reassignments attached to the group member is deleted.

If the applicant makes a change to its practice location, and that location is within the same carrier's jurisdiction but within another State, it must provide the state license with that change. (Not applicable for intermediaries.)

Any change to a Pay-to-Address requires the contractor to verify/validate this request. See section "Pay-to-Address" for further instructions.

Processing the Change of Information

The contractor must process 90 percent of applications that are requesting a change of information within 45 days or sooner. 99 percent of applications must be processed within 60 days. This process includes:

- Receipt of the application in the mailroom and forwarding the application to the appropriate office for review,
- Contractor's review and verification of the requested change,
- Any request or contact needed with the applicant, and
- The requested change updated in both the contractor's system and UPIN registry.

Anytime a request for change is received, provide written (or via Email) confirmation that the change has been made. This also may be accomplished by telephone. Document *(per Section 25 of this manual)* in the file the date and time the confirmation was made. In certain situations the contractor has discretion when making this contact. For example, where an area code/zip code has been changed for the entire community, it is not necessary to send confirmation that this change has been made to the provider/supplier's file.

If a hospital is adding a practice location make the confirmation to the provider in writing with the disclaimer, “We have added the practice location to our records in accordance with your request. However, this does not constitute approval of the facility as provider-based under section 413.65 of the code of Federal Regulations.”

14 - Procedures for Request for Additional Information, Approval, Denial, or Transmission of Recommendations - (Rev. 41, 05-23-03)

14.1 - Request for Additional Information – (Rev. 41, 05-23-03)

Request additional information first verbally and (in most situations) *the contractor can receive the additional information by fax when working with an application that has an original signature. For example, if the contractor receives an initial application (with an original signature) and notices that information is missing, request the applicant to forward the additional information by fax when requesting written documentation. Along with the faxed information, they must sign the certification statement and date it.*

Compare the original signature from the original application against the signature on the faxed certification statement. The faxed certification statement supports the information that has been sent by fax. Both copies of the certification statements must be kept on file. The file would show the application with an original signature and the faxed information will have a faxed certification statement. The two certification statements must match.

The contractor must review the application in its entirety prior to contacting the applicant concerning the application. *The only exception would be if the contractor determines that an application would be denied during the prescreening phase. If that is the case, refer to §14.3, denials.* After contacting the applicant for additional information/clarification, make sure that the contractor can distinguish any responses to written requests for additional information from new applications in the incoming mail. Failure to do so may cause the contractor to not meet the timeliness requirement. Always require a new certification statement (signature and date) for information requested in writing*/or by fax*. The contractor may use the following stock language when requesting additional information:

Dear Applicant:

( ) This is a follow-up to a telephone conversation today, (date), requesting additional information. -Please make sure that along with the requested information, you include a newly signed certification statement and/or attestation statement. *You can submit this information by fax (provide a telephone number).* If we do not receive the required documentation within 14 days, the processing of your application will be delayed. If you have already sent the documentation, please disregard this letter.

( ) We have tried to contact you by telephone on (date) concerning your recent request to enroll in the Medicare program. During our review of your application, it was noted that certain information is either missing or cannot be verified. Prior to being approved for a billing number, we must receive the requested information within 14 days. Failure to provide this information within 14 days will delay the processing of your application. Please make sure that along with the requested information, you include a newly signed certification statement and/or attestation statement. *You can submit this information by fax (provide telephone number).*

You must sign and date the certification statement in order to be enrolled in the Medicare program.

If the only information missing is supporting documentation, you do not need to get a new certification signature/date. *Also, if the application is missing information, but the contractor can locate it internally within its own files or on another part of the application, it is not necessary to develop for the information. Always document where the information was found and continue to process the application.*

14.2 - Approval *and Recommendations for Approval* – (Rev. 41, 05-23-03)

The carrier should notify the applicant that it has been enrolled as a Medicare supplier and forward to the applicant a Medicare billing number. Except for DMEPOS suppliers, pay all supplier claims that satisfy existing Medicare requirements including, when permissible, claims for services furnished prior to the enrollment date. For claims submitted prior to enrollment for physicians and non-physician practitioners, see MCM §3004 for the claim filing limit. Payment cannot be made for services prior to the date the applicant is appropriately licensed. For initial enrollment, the carrier should use the date that the supplier started practicing at the practice location as the date it can begin submitting claims.

NOTE: A DMEPOS supplier, however, can be paid only for claims furnished after the enrollment process has been completed and a supplier number has been assigned.

When an intermediary or carrier reviewing a certified supplier (portable X-ray, ASC) completes its review of the application, a recommendation for approval or denial shall be submitted to the RO and to the state agency for providers subject to an onsite state agency survey. The recommendation must include a copy of the final completed application (Form CMS-855 with any updated pages and explanatory information) except when the contractor is sure that they already have final copies. All final sales agreements should be included. A Change of Information, or a CHOW application from the outgoing old owner where the new owner has submitted its CHOW application, does not require a recommendation for approval. However, if there is a reason to recommend denial, then a recommendation for denial should be issued. A recommendation for denial or approval should have all relevant correspondence and/or documents attached.

The recommendation should include the following information:

State Agency or RO Control Number (if available)
Supplier/Provider NPI Number (if available)
OSCAR Number (if available)
Carrier/Intermediary Number
Carrier/Intermediary Contact Name
Carrier/Intermediary Contact Phone Number
Date Application Recommended for Denial/Approval
Reason for Recommendation for Denial cite one of the reasons listed in section 14.3)/recommendation for approval.

Upon issuance of a recommendation for approval, or acceptance of a Change of Information after any required verification, the applicant should be informed that the intermediary/carrier has

completed its initial review of the application. This information can be provided orally or in writing. Except if must be in writing, in accordance with the §13 disclaimer, when a hospital is adding a practice location. If this is performed orally, annotate the file. When applicable, the applicant should be advised that the next step of the enrollment process involves a site visit, survey or other information reviews, conducted by the state survey agency, the CMS RO, or by a contractor, to determine the applicant's compliance with state and Federal participation requirements. Provide the applicant with a phone number for the organization that is involved with the next enrollment step. If the applicant calls the FI or carrier after the recommendation for approval, have the customer service representative or provider enrollment staff advise them to discuss their status with the organization that performs the next step in the enrollment process.

14.3 - Denials – (Rev. 41, 05-23-03)

Carriers must only deny an application and intermediaries can only recommend a denial to the RO if the following situations described below are discovered during the review process. Anytime an application is denied, it must be maintained as required in §*21*, Retention of Records. Always provide appeal rights to all applicants whose applications are denied (this does not apply to intermediaries). A recommendation to deny the application is made to the RO and the state agency for state surveyed providers, when one of the conditions are discovered. *However, for a recommendation for denial, the contractor should be sure that the applicant really is required to meet the conditions prior to a recommendation. For example, an applicant lacking a state license which can only be obtained after a state survey should not receive a recommendation for denial.*

Whenever a decision is made to deny (recommend a denial) make sure that the reason for the denial is documented clearly. If it is found that the contractor had to deny the application for two reasons, annotate that in the letter. Always support this decision based on the appropriate regulation/statute.

Denial 1

The applicant, owner, Partner, managing organization/employee, officer, director, ambulance crewmember, Medical Director, and/or delegated or authorized official is excluded from a Federal program (as set forth in either §1862(e)(1) *of the Social Security Act (the Act)*; 42 U.S.C. §1395y(e)(1), 42 CFR §1001.1001, §1001.1901 or is/are debarred from Participating in a Federal procurement or non-procurement program; (as set forth in §2455 of the Federal Acquisition Streamlining Act of 1994, Pub. L. No. 103-55 (1994).

Anytime an excluded Party is found, notify Benefit Integrity/PSC immediately. The Benefit Integrity/PSC Unit needs to contact the OIG's office with the findings for further investigation. For a previously excluded applicant that is requesting to reenroll in the program, contact the OIG to verify that it is now eligible to enroll in the Medicare program.

Denial 2

The applicant does not have license(s) or is not authorized by the Federal/State/local government to perform the services for which it intends to render. (In the denial letter or recommendation to deny, list appropriate citations, e.g., *§*1861(r) or *§*1861(s) *of the Act.*

Denial 3

The applicant does not have a physical business address *or mobile unit* where services can be rendered and/or does not have a place where patient records are stored to determine the amounts due such provider or other person (as set forth in *§*1833(e) *of the Act*.

Denial 4

The applicant does not meet CMS regulatory requirements for the specialty. (In the denial letter, list appropriate regulation citation.)

Denial 5

The applicant does not qualify as a provider of services or supplier of medical and health services. An entity seeking Medicare payment must be able to receive reassigned benefits from physicians in accordance with the Medicare reassignment statute in §1842(b)(6) of the Act (42 U.S.C. 1395u(b)).

Denial 6

The applicant does not provide a valid SSN/employer identification number for the applicant, owner, Partner, managing organization/employee, officer, director, ambulance crewmember, Medical Director, and/or delegated or authorized official.

Denial 7

If the applicant does not meet the capitalization requirements issue a recommendation for denial. If the carrier determines that the applicant should be denied enrollment or if the FI recommends a denial to the RO because of failure to meet one or more of the above requirements, enter this information in the provider file. Once you complete the process, carriers should inform the applicant of the reason(s) for denial and provide the applicant appeal rights, see §13. The contractor may use the following stock language.

Denial 8

If the applicant deliberately falsifies, misrepresents, or omits information contained in the application or deliberately alters text on the application form, issue a denial or recommendation for denial.

If the contractor determines that the applicant must be denied enrollment or if the FI recommends a denial to the RO because of falsifying, misrepresenting, or omitting information, deny the application (or make a recommendation to deny) and support this decision based on the

application's certification statement.

Prior to making a decision to deny an application (or making a recommendation to deny) for the above reason, consult first with the Regional Office (RO) to make sure that this denial is appropriate for the above reason. Once the RO decides to deny (or upholds the recommendation to denial), the FI must contact the state agency regarding the decision. The carrier must inform the applicant of the reason(s) for denial and provide the applicant with appeal rights, see §13.

Following is stock language for any denial that is listed above.

(Date)
(Name and Address)

(Document Control Number)

Dear Supplier:

Your request to Participate in the Medicare program is denied. After careful review of your health care provider/supplier application it was determined that you do not meet the conditions of enrollment or meet the requirement to qualify as a health care supplier because (list the reason*(s)* for denial as stated above). Therefore, your application is being denied and you cannot receive Medicare payment.

You may, of course, take steps to correct the deficiencies and reapply to establish your eligibility.

If you believe that this determination is not correct, you may request a hearing before a carrier-hearing officer. The carrier hearing is an independent review and will be conducted by a person who was not involved in the initial determination. You must request the hearing in writing to this office within 60 days of the date you receive this notice (presumed to be 5 days after the date of the notice.) The appeal should be sent or delivered to:

(CONTRACTOR'S ADDRESS)

You may submit with the appeal request any additional information that you believe may have a bearing on the decision. The hearing can be held in person or by telephone at your request. Failure to timely request a carrier hearing is deemed a waiver of all rights to further administrative review.

You may not appeal through this process the merits of any exclusion by another Federal agency. Any further permissible administrative appeal involving the merits of such exclusion must be filed with the Federal agency who took the action.

Sincerely,

(Provider Enrollment Specialist Name)
Medicare Part B Contractor

14.4 – Revocations – (Rev. 41, 05-23-03)

Carriers must revoke a billing number and intermediaries must recommend a revocation of a billing number to the RO if the following situations described below are discovered once a provider/supplier is enrolled. Anytime a provider or supplier number is revoked, it must be maintained as required in § 21, Retention of Records. The carrier/RO must provide appeal rights to all providers/suppliers whose billing number is revoked. A recommendation to revoke the provider is made to the RO and the state agency for state surveyed providers, when one of the conditions is discovered.

Whenever a decision is made to revoke (recommend a revocation) make sure that the reason for the revocation is documented clearly. If there is cause to revoke the number for two reasons, annotate both reasons in the letter. Always support this decision based on the appropriate regulation/statute.

Revocation 1

The provider/supplier, owner, Partner, managing organization/employee, officer, director, ambulance crewmember, Medical Director, and/or delegated or authorized official is excluded from a Federal program (as set forth in either §1862(e)(1) of the Social Security Act (the act); 42 U.S.C. §1395y(e)(1), 42 CFR §1001.1001, §1001.1901 or is/are debarred from Participating in a Federal procurement or non-procurement program; (as set forth in §2455 of the Federal Acquisition Streamlining Act of 1994, Pub. L. No. 103-55 (1994).

Anytime an excluded Party is found, notify Benefit Integrity/PSC Unit immediately. The BI Unit needs to contact the OIG's office with the findings for further investigation.

Revocation 2

The provider/supplier has lost its license(s) or is not authorized by the Federal/state/local government to perform the services for which it intends to render. (In the revocation letter or recommendation to revoke, list appropriate citations, e.g., §1861(r) or §1861(s) of the Act.

Revocation 3

The provider/supplier no longer has a physical business address or mobile unit where services can be rendered and/or does not have a place where patient records are stored to determine the amounts due such provider or other person (as set forth in §1833(e) of the Act.)

Revocation 4

The provider/supplier no longer meets CMS regulatory requirements for the specialty. (In the revocation letter, list appropriate regulation.)

Revocation 5

The provider/supplier no longer qualifies as a provider of services or supplier of medical and health services. A provider/supplier seeking Medicare payment must be able to receive reassigned benefits from physicians in accordance with the Medicare reassignment statute in §1842(b)(6) of the Act (42 U.S.C. 1395u(b)).

Revocation 6

The provider/supplier (upon discovery) does not have a valid SSN/employer identification number for itself, an owner, Partner, managing organization/employee, officer, director, ambulance crewmember, Medical Director, and/or delegated or authorized official.

Revocation 7

The provider/supplier no longer meets the capitalization requirements.

Revocation 8

If it is discovered that the provider/supplier deliberately falsified, misrepresented, or omitted information contained in the application or deliberately altered text on the application form, issue a revocation or recommendation for revocation.

If the contractor determines that the provider/supplier must be revoked or if the FI recommends a revocation to the RO because of falsifying, misrepresenting, or omitting information, revoke the billing number (or make a recommendation to revoke) and support this decision based on the application's certification statement.

Prior to making a decision to revoking (or making a recommendation to revoke) an application for the above reason, consult first with CO (Division of Provider & Supplier Enrollment) to make sure that this revocation (recommendation to revoke) is appropriate for the above reason. Once CO makes a decision to revoke a billing number is made, FI must contact the RO and the state agency and carriers must inform the applicant of the reason(s) for the revocation and provide the provider/supplier with appeal rights, see §13.

15 - Time Frame for Application Processing – (Rev. 41, 05-23-03)

Timeliness expectations are not paramount over development and detecting fraud or abuse. If an application requires developmental procedures not outlined in this manual, document and support any action you made within the file. In those few situations where an extension is needed for investigative purposes, contact the RO provider enrollment contact person to request an extension. Intermediaries will not need to make this request in the following situations, but should always document the file *accordingly*:

- CHOW determination to RO after 10 days at RO (if rest of the intermediary processing is done in 60 days)*;*

- *A waiting provider-based decision from the RO, only when specifically required or requested by the RO. Extension time starts after 10 days at RO (if rest of the intermediary processing is done in 60 days.);*

- Waiting for a sales agreement in future (if rest of the intermediary processing is done in 60 days)*; and*

- Waiting for RO on capitalization after 10 days at RO (if rest of the intermediary processing is done in 60 days)

If an application is pended for further investigation by Benefit Integrity/PSC, annotate this action in the file. The Benefit Integrity has 10 days to process the provider enrollment unit's request. If the timeframe cannot be met, Benefit Integrity must call the RO provider enrollment contact person to request an extension for this particular case. These actions must be documented. *Contractors that use a PSC for the investigation will be granted an automatic processing time extension for any PSC processing time beyond 10 calendar days. The days for PSC processing shall be calculated from the date of the request to the PSC until receipt of the PSC reply. The contractor must document the request date to the PSC and the reply date.* Upon receipt of the action required by Benefit Integrity/PSC, immediately begin processing the application based on the recommendation.

<u>Processing the Initial Application (Including CHOWS, Acquisitions, Mergers and Consolidations for FIs)</u>

Process 90 percent of applications within 60 calendar days of receipt or sooner. Process 99 percent of applications within 120 calendar days of receipt. This process includes:

- Receipt of the application in mailroom and forward to appropriate office for review*;*

- Prescreen the application in its entirety, as outlined in this section*;*

- Enter the information into PECOS (if applicable)*;*

- *Contact with the applicant (first by telephone and when necessary in writing);*

- Verification of the application*;*

- The time it takes for the applicant to respond*;*

- Mailing/handling time to receive the requested information*;*

- The time (10 days to process) for Benefit Integrity/PSC to respond to a provider enrollment's request*;*

- Making a decision (or recommendation) to assign or deny a billing number*;*

- Formal notification of the carrier's decision (and provide the appropriate appeal rights (see section 13), as necessary)*; and*

- Supplier site visit--an extension may be given if it is a site visit to a remote location. To obtain this extension, contact your RO.

Certified providers are considered closed after the recommendation for approval/denial.

Date Stamping

As a general rule, all incoming correspondence must be date-stamped. This includes, but is not limited to:

- *Initial Forms CMS-855A, 855B, 855I and 855R applications. The first page must be date stamped.*
- *Letters from providers/suppliers. The first page must be date stamped.*
- *Articles of Incorporation/Partnership agreements, billing agreements, etc. The first page of the document or the envelope must be date stamped.*
- *When a provider/supplier submits a change and does not have a Form CMS-855 on file. The first page of the changed information must be date stamped.*
- *Once an initial (first submission) of Form CMS-855 changes are on file, any new additional changes received must have all pages date stamped.*
- *Additional Information received based on your request. All pages must be date stamped.*

CMS is distinguishing from an initial (first submission) application from one that is being submitted for changes. Because most contractors interleaf the changed pages with the original application, it is necessary to determine the sequence in which the application/pages were received. Therefore, when the contractor received an initial application, it is only necessary to date stamp the first page of the application. However, in situations where the contractor requests additional information and additional pages are submitted, all the resubmitted pages must be date stamped. The rules for changes of information apply the same as that of requests for additional information.

The first page of the above documents and envelopes must be date-stamped in the mailroom. If the mailroom has a difficult time distinguishing a request for change from an initial application, the Provider Enrollment unit can date stamp the additional pages. However, long time lapses shouldn't be noticed from the time it was received in the mailroom until the time the Provider Enrollment Unit date stamps the pages.

Processing Times for *Form* CMS-855Rs, Changes and Reactivations

Process any Form CMS-855R, request for change, and reactivation that is not with an initial enrollment within 45 calendar days of receipt or sooner 90 percent of the time. Process 99 percent of these type of applications within 60 days of receipt.

This process includes:

- Receipt of the application in mailroom and forward to appropriate office for review*;*
- Review and verification of the changed information*;*
- Entering the information into PECOS (if applicable)*;*
- Contact with the applicant (first by telephone or when necessary in writing) for clarification or additional information*;*
- The time it takes for the applicant to respond*;*
- Mailing/handling time to receive any requested information*;*
- An onsite visit for suppliers who may require one*;*
- The time (10 days to process) for Benefit Integrity/PSC to respond*; and*
- Updating the system

Prescreening

To better manage workloads, a prescreen of the application must be made within 15 *calendar* days of receiving an initial Form CMS-855I, Form CMS-855B, or Form CMS-855A (and the clock starts the day the application is received in the corporate mailroom). It must be date stamped in the mailroom. As Part of this process, analyze the application for any missing information (e.g., no phone number; lack of documentation). The point of prescreening is to find any obviously missing data elements. The contractor is not required to begin the verification process during the 15-day period, although they may do so.

If information is missing, make an initial contact by telephone, *E-mail* or send a corresponding letter for additional information within 15 days *of receiving the application. Again, make the initial contact within the original 15-day prescreening period.* Sending out a letter or making a telephone call is sufficient to satisfy this requirement. *(Carriers: When making this initial contact, you must also ask the supplier whether he/she wishes to be Participating or non-participating if the application does not indicate so.)* It is not necessary to actually talk to or receive a written reply from the applicant within the 15-day period. For instance, if the contractor telephones the applicant on the 12th day, this requirement is met, even if the applicant did not return the call until the 17th day. Do not hold up the application for verification while waiting for the additional information. If ready, begin the verification process while waiting for the missing information.

For intermediaries the prescreening process should be used to determine when information is actually required based upon: 1) The type of transaction the applicant is requesting (CHOW from

old owner, CHOW from new owner, Merger, Acquisition, Consolidation, initial application, etc., 2) The information that the intermediary already has in its records about the provider/facility, and 3) Information obtained from the other Party in a sales transaction. In conjunction with the above, the reviewer shall review *Form* CMS-855A completion instructions and manual instructions. The same considerations should be applied when performing verification and obtaining information not provided on an application.

Verification

The verification process may begin at any time during the processing timeline. The purpose of the verification process is to determine if any of the information received conflicts with the executive summary prepared by Qualifier.net, the attached supporting documentation, or other information present in the records. At any time during the verification phase, the contractor can contact the applicant orally for clarification/information. If additional data is needed in writing that was not previously requested during the prescreening phase, allow the applicant 14 days to respond to this request. *Note that all Qualifier.net executive summaries are valid for 120 days.*

Process an application without contact

Review the application in its entirety. If the contractor finds data elements that are missing and can validate the data from a valid source (including the contractor's records) or confirm them from supporting documentation submitted with the application, continue to process the application without contacting the applicant directly. We have determined that just because information is missing or this information is unable to be verified, it doesn't necessarily require that you make a request for additional information. However, data requirements, that do not require oral confirmation, are few.

Oral information or clarification

After the completion of the prescreen review of the application in its entirety, annotate what type of information is missing or needs clarification. Immediately contact the applicant for the missing information, as it will be used during the verification phase of the enrollment process. *If the applicant has not provided supporting documentation (such as a license), it* is not necessary to request this information in a written letter. If for some reason the contractor has been unsuccessful in its attempt to contact the applicant directly, follow procedures for written requests. Allow 1-week to connect with the applicant by telephone. Do not return the original application. If unable to connect with the applicant by telephone, request the information in writing. Retain a copy of the developmental letter on file as well as the validation it developed from the data validation sources.

Upon receipt of the written information, and since you developed the application in its entirety and have retained the data validation documentation on file, only validate the new information. Any time a file is closed, document the reason for closing the file. If an applicant returns the requested information late, indicate this in the file. If the information verified in the closed folder

is less than 60 days old, verify the requested information and do not treat the application as a new one. Always accommodate the applicant to the best of your ability.

In situations where you have made at least three attempts to contact the applicant for information, and the applicant is not responding to those requests, close the application after 120 days. The first request happens in the prescreening phase when the contractor makes the telephone call to the applicant to request information. A second request could be made during the verification phase, either as a follow-up from the prescreening phase or a request for additional information not previously requested. This request/clarification can be made by telephone, and when necessary, in writing. If after 14 days the applicant has not responded, you must contact the applicant once more for the information. If the applicant fails to provide any of the required data within 7 days, close the file after 120 days. Anytime the information is received during the 120-day cycle, process it even if the delay in processing was not caused by the contractor. Therefore, if the applicant waited until the 99th day to send the information, the contractor is required to process it, and take one count.

At this time we do not have a way to track those applications that are late based on the applicant being delinquent. Therefore, if the contractor has the ability to track this data, and would like to submit it to the RO to consider for timeliness purposes, do so.

After closing the application, contact the applicant using the following draft language:

> "Dear Entity:
>
> We received your enrollment application on _____. We have tried to reach you several times to request additional information that is required to process your application. Unfortunately, you did not respond or only sent a portion of the requested information. Therefore, we are closing your application at this time. If at a later date you want to enroll in the Medicare program, you will need to resubmit your application."

Once the PECOS is operational, we will capture this information to show that the applicant is non-responsive.

Request for Written Information

Certain documentation is critical in the pursuit of legal issues. The applicant must document and certify certain data elements, and therefore, missing information or clarification must be submitted on a revised application to Medicare. All changed/missing data elements must be accompanied with a signed/dated certification statement. Such examples include the name, sanction information, and adverse legal information. Always retain the original application on file. The reason to do so is to make sure that the information validated through Qualifier.net is not compromised. Send the applicant a blank application and send a letter annotating what data fields are missing or need clarification. Also when a blank application is returned for additional information, always attempt to make a telephone call to the applicant/contact person to discuss the reason for the return. The telephone call is to alert the supplier/contact person what additional information is required and to help facilitate the processing of the application. We also suggest

that you mail the request for the additional information and make the telephone call concurrently. It is suggested to allow 7 days for the contact to be made. Allow the applicant at a minimum 14 days to submit the requested information. You can also inform the applicant that the applicable section(s) of the 855 forms can be downloaded from our Web site. In those situations where the applicant has the capability to do so, instruct the applicant to download the file and complete the data element you need. Remind the applicant that it must also provide a signed certification statement or the application will be returned.

For situations when both data requirements fall under two headings "Request verbal information or clarification" and "written information required," follow the procedures as a written request.

NOTE: Do not pay claims until the application is complete and the provider/supplier is enrolled. This is not for fiscal intermediaries on CHOWS, Acquisitions/Mergers and Consolidations, as special instructions should be followed to stop payment only when required.

Clarifications

Review of the application may result in questions or a need for information from the application, which may not result in an actual change to the application. If this is the situation, make a telephone call to request clarification. The determination to request additional information with a formal letter, or a telephone request, as appropriate, is within your discretion.

16 - Verification and Validation of Information – (Rev. 41, 05-23-03)

Do not write on the original Form CMS-855 applications. The use of a highlighter on the original application is also prohibited. Provider usage of white-out is acceptable, although the contractor should contact the applicant to resolve any ambiguities or suspicions. In addition, the contractor must determine whether the amount of white-out used on a particular application is within reason. For instance, if an entire application page is whited-out, the carrier should perhaps request that the page be resubmitted. The contractor must use its best discretion in these situations.

Telephone Development

When developing the application *by telephone*, a report of contact must be prepared. The report of contact can either be a hardcopy or in an electronic format and, at a minimum, show the name of the person contacted, the name or initials of the person who made the contact, the date of the contact, and a summarization of what is being added. *(See §25, Documentation, for further information.)* This report of contact must be made Part of the permanent record and should be easily accessible. The contractor must retain this information in accordance with the guidelines as outlined in Section 21, Retention of Records. Do not write directly on Form CMS-855 to capture any information not previously submitted.

In situations where the contractor is aware of a zip code changing or an area code changing *in a particular geographic area*, it is not necessary to develop a report of contact for each applicant. However, a generic file (either electronic or hardcopy) should be kept to show that changes were

made to the database that impacts the original Form CMS-855. This file should also be easily accessible.

Non-telephone Development

When developing applications for information that may not be developed via telephone, use highlighter on a blank Form CMS-855 to identify those sections that need to be completed.

NOTE: The original application must never be returned to the applicant *unless otherwise stated in the PIM (see Forms Disposition)*. A blank copy of the appropriate Form CMS-855 must be sent with the highlighted areas identified to show what additional data is needed to complete the process. A developmental letter must also be sent to explain the request for additional information. Once the additional information is received, add this information to the permanent record. The information must be retained in accordance with the guidelines as outlined in Section 21, Retention of Records.

Qualifier.net

To ensure the validity and accuracy of the data furnished on the Form CMS-855, verify the application using Qualifier.net. Do not *use any other data validation source, unless otherwise specified or permitted in these instructions.*
If a discrepancy is found between the information furnished by the applicant and *Qualifier.net*, try to query a second source to confirm the data. Possible second sources to validate include the IRS for tax identification number; the American Medical Association for medical license, board certification and education, the public phone directory; the state licensing board for professional and business license; or any reliable Internet data source.

If the discrepancy cannot be resolved, request additional information *to help resolve the unverifiable information*. If the applicant insists that the data provided were correct, the contractor may want to do an onsite visit although the visit is not mandatory.

If the applicant has checked that he/she has been convicted of any health care related crime, convicted of a felony, etc, refer the case to Benefit Integrity/PSC for further development prior to enrolling the applicant. The Benefit Integrity/PSC *(and/or the OIG)* will make the determination as to whether or not to enroll the applicant.

The contractors should develop editing and matching procedures to identify situations that might indicate fraudulent or abusive practices. The contractors shall have the capability to produce reports from their findings, at CMS's request, on an ad hoc basis. The following edits and matching procedures are required:

- Correlation of all ownership information, such as owners, managers and related businesses, to identify individuals or businesses that are common to multiple providers/suppliers*; and*

- Check all previous/current provider/supplier numbers and all previous/current locations for those providers/suppliers with revoked numbers for fraudulent or abusive practices

Qualifier.net and Submission of Documentation

Applicants are required to submit all supporting documentation with their application. Such documentation includes certificates, registrations, school degrees, vehicle identification data, etc. If the applicant fails to submit such documentation with its initial application, but the contractor is able to verify the data through Qualifier.net, the contractor need not request the documentation from the applicant. For instance, suppose a physician failed to include a copy of his license with his Form CMS-855I. After the review in Qualifier.net , the contractor finds that he is currently state licensed. Do not ask the applicant for a copy of his state license, since you are able to validate this information through Qualifier.net. However, you retain the right to do so, if the contractor chooses.

Of course, if Qualifier.net cannot or does not validate this information, request a copy of the applicable documentation.

16.1 - Fraud Investigative Database – (Rev. 41, 05-23-03)

The contractor shall review the FID against all names listed on the application *that show it has or previously had a Medicare identification number.* This includes the applicant, owners, managing organizations/employees, Partners, officers, directors, authorizing officials, etc. In instances where a name appears in the FID, provider enrollment staff are expected to alert Benefit Integrity/PSC while continuing to process the application. The Benefit Integrity/PSC should advise the provider enrollment staff on how the application should be handled while the investigation is being conducted and if administrative action is needed (e.g., flagging provider for prepay/post pay review) within 10 days. Never inform the applicant that a name has appeared in the FID as this information is strictly confidential.

If the provider enrollment unit has found a "hit" on the FID and is waiting for further action from its Benefit Integrity/PSC, the processing time stops to allow the appropriate time to investigate this issue.

16.2 - Healthcare Integrity and Protection Data Bank - (Rev. 41, 05-23-03)

Provider enrollment units are to obtain access to the HIPDB and to review all names and entities listed on the application (or obtained through *Qualifier.net*. These persons and entities include the applicant, owners, managing employees, authorized officials, etc. If a reviewed name appears on the HIPDB and there is a question as to whether the adverse action is grounds for a denial, refer the matter to Benefit Integrity/PSC. While the matter is with Benefit Integrity/PSC, the processing time stops to allow Benefit Integrity/PSC appropriate time to investigate the issue. Once Benefit Integrity/PSC has decided how to handle the application, the provider enrollment staff must continue to process the application immediately.

If the adverse action clearly does not constitute grounds for denial, continue to process the application. Flag the application, however, so that Benefit Integrity/PSC may determine whether future claims submitted by the provider warrant heightened scrutiny.

16.3 - Uncovering Fraud and Abuse – (Rev. 41, 05-23-03)

Criminal penalties may be imposed by the government against an individual or organization who in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals, or covers up by any trick, scheme or device a material fact, or makes any materially false, fictitious, or fraudulent statement or representation, or makes or uses any false writing or document knowing the same to contain any false, fictitious, or fraudulent statement or entry. If the contractor uncovers such fraud or abuse on Form CMS-855, alert the BI Unit.

16.4 – *Excluded Parties List System (General Service Administration (GSA) Debarment)* – (Rev. 41, 05-23-03)

If a potential hit is found on the *Excluded Parties List System* (through the review of *Qualifier.net*) and the contractor needs to make a positive identity, contact the agency that took the action. Based on the information the agency has about the applicant, determine if it is the same person. Upon contacting the agency, advise it *that* you are trying to identify this person for a positive match because CMS is prohibited from making payments to an entity that has been debarred from another Federal agency. If unable to make a confirmation and the hit appears to still be questionable, refer this Benefit Integrity/PSC. The benefit integrity unit/PSC must investigate to determine if it is the same person/entity. If the contractor cannot make a positive match, approve the application. Make sure that all actions regarding the investigation are documented.

17 - Special Processing Situations - (Rev. 7, 05-31-01)

17.1 - Mass Immunizers Who Roster Bill - (Rev. 29, 07-26-02)

If the state law allows a pharmacist to immunize, the carrier will enroll the pharmacist as an individual. If the pharmacist does not have a practice location (since most of his/her services are provided at local malls, community centers, etc.), request the applicant to enter the address where his/her records are stored. The address cannot be a post office box.

Applicants who enroll in the program as mass immunization/roster billers cannot bill Medicare for any services other than influenza and penumococcal pneumonia vaccines. The claims processing system must note that the applicant has filed to bill for influenza/PPV only. If the applicant is eligible to bill for other services, it must qualify as a different supplier/specialty type.

All mass immunizers and roster billers must agree to accept assignment of the influenza/penumococcus benefit as payment in full and cannot "balance bill" the beneficiary.

17.2 - Opt-Out Physicians - (Rev. 29, 07-26-02)

Opt-Out Physicians or Practitioners

Section 1802 of the Social Security Act, as amended by §4507 of the BBA of 1997, permits a physician or practitioner to "opt out" of Medicare and enter into private contracts with Medicare beneficiaries if specific requirements are met. For enrollment purposes, enumerate the "opt out" physician by using the data elements provided in the affidavit (if he/she does not have a UPIN). See MCM 3044.13. In an emergency care or urgent care situation, a physician or practitioner who opts out may treat a Medicare beneficiary with whom he or she does not have a private contract. In those circumstances, the physician or practitioner must complete the application after the emergency services were provided.

Mandatory Participating Physicians

Some practitioners who provide services under the Medicare program are required to accept assignment for all Medicare claims for their services. This means that they must accept the Medicare allowed charge amount as payment in full for their practitioner services. The beneficiary's liability is limited to any applicable deductible plus the 20 percent coinsurance. The practitioners' services to which mandatory assignment applies are services of:

- Physician assistants;
- Nurse practitioners;
- Clinical nurse specialists;
- Clinical psychologists;
- Clinical social workers;
- CRNAs;
- Nurse midwives; and
- Registered dietitians and Nutrition professionals

For practitioner services of physicians and independently practicing physical and occupational therapists, the acceptance of assignment is not mandatory. Nor is the acceptance of assignment mandatory for the suppliers of radiology services or diagnostic tests. However, these practitioners and suppliers may nevertheless voluntarily agree to accept assignment on all Medicare claims. Such an agreement is known as a Participation agreement. (See Exhibit 1.)

17.3 - Enrollment of Hospitals, Assignment of Billing Numbers – (Rev. 29, 07-26-02)

Hospital Form CMS-855As Processed by the Intermediary

Intermediaries shall review all Form CMS-855As for hospitals. This review includes all practice locations listed and departments listed. This is applicable for new applicants and for CHOWs. The intermediary shall mail a copy of the recommendation for approval or denial and the Form CMS-855A to any applicable carriers (those who will provide carrier billing numbers for the applicant). The intermediary shall document that this has been accomplished.

Hospital Form CMS-855A changes (e.g. practice location address changes, additions and deletions), all of which are now required to be shown on the Form CMS-855A, must be reviewed by the intermediary. Within five (5) working days of the completion of *its* review, the intermediary must advise the applicable carrier by telephone and provide *it* with a copy of the Form CMS-855A. The intermediary shall document that this has been accomplished.

Hospital Form CMS-855Bs Received and Processed by the Carrier

Carriers shall review all Form CMS-855Bs for hospital owned clinics/physician practices and department billings. The carrier shall call the applicant to determine if the applicant will be billing any of these as provider-based.

If the applicant will not bill the practice location or department as provider-based, then process the application using the same procedures as for any other clinic/physician practice.

If the applicant will bill as provider-based, advise the applicant that the hospital must report any changed practice location to the hospital's intermediary. Advise the hospital that if they have not previously submitted a Form CMS-855A, then a complete Form CMS-855A is required for a new hospital. A Change of Information, Form CMS-855A, is required for a hospital adding a practice location or making other changes. The carrier must document that they have taken these actions.

For new hospital applications to be submitted on Form CMS-855B, the carrier shall: 1) Review, all Form CMS-855Rs attached and determine if there is W-2 or 1099 relationship, and process accordingly, 2) Review the application in accordance with the standard manual procedures, and 3) Prepare their system for prompt issuance of any applicant requested departmental billing numbers. The carrier shall only complete their final processing, (e.g., issuance of a billing number(s), final system process of Form CMS-855Rs) promptly upon notice that a provider agreement has been issued. However, the application shall be considered as processed (as concerns enrollment processing time), upon completion of *its* review. Within five (5) working days of the completion of their review, the carrier must advise the applicable intermediary by telephone and provide them with a copy of the Form CMS-855B. The carrier shall document that this has been accomplished.

For CHOWs (not applicable if the new owner will not accept assignment of the provider agreement), payment can continue, including reassignments of benefits. The carrier shall, on a priority basis: (1) Review all Form CMS-855Rs attached and determine if there is an employer employee relationship, W-2 or 1099, and process accordingly, (2) Review and verify Form CMS-855B in accordance with standard manual procedures, and (3) Prepare their system for prompt issuance of any applicant requested departmental billing numbers. New Form CMS-855Rs are required in the case of a CHOW since the new owner must sign Form CMS-855R. However, the new owner shall be given at least 30 days after the effective date of the provider agreement's assignment/transfer for submission of the new Form CMS-855Rs. The carrier shall only complete their final processing, (e.g., issuance of TIN change, any billing number(s) changes, and final system process of the Form CMS-855Rs) promptly upon notice that the provider agreement has been assigned to the new owner/applicant.

Hospital Enrollment Communication Among Intermediaries, Carriers and the RO

The hospital enrollment procedures above are designed to ensure that the intermediary, carrier and RO have all the relevant required enrollment information for a hospital. This will facilitate any enforcement initiatives and or instructions concerning provider-based status.

Transitioning From Provider-based to Free Standing

If a hospital clinic or outpatient department that is being paid as provider-based desires to be converted to free-standing status, a new Form CMS-855B is required. The carrier shall have completed the Form CMS-855B review prior to any payments being made to the new free-standing entity. The intermediary must be advised of the change via a change to the hospital's Form CMS-855A. To the maximum extent *possible,* these changes must be given priority treatment. Both the carrier and intermediary shall coordinate a seamless transition between the provider-based status and free-standing status. We do not desire to stop payments for the services which are being continuously provided. Appropriate coordination and guidance for these transitions shall be provided by the RO.

17.4 - Railroad Retirement Board (RRB) – (Rev. 29, 07-26-02)

The RRB cannot process a claim for a Medicare beneficiary until it is determined that the physician/supplier has been enrolled in the Medicare program by a contractor. Therefore, if the contractor receives a request to provide the RRB with a Medicare identification number, do so. Cooperate and provide this information within 5 working days of the request. We encourage contractors to answer all questions timely to help facilitate the processing of RRB claims.

NOTE: FIs are not involved with RRB enrollment.

17.5 – Provider-Based Processing and Changes in Status – (Rev. 41, 05-23-03)

If a separately enrolled entity, other than a clinic or hospital outpatient department (i.e., a HHA, SNF, etc.) makes a request to change its status from, provider-based to freestanding or from

freestanding to provider-based, the following procedure applies. The provider type who is changing their enrollment status should submit Form CMS-855A and complete the following sections. Complete section 1A1, 1A2 and 1A3. In section 1A1 they should check, "Change of Information." In block 2A2 they should check, "Other (Specify)" In block 2G they should explain the change they are requesting. They should then sign the Certification Statement in section 15. If there is no certification statement signature on file, then the individual who signed the certification statement should be listed in Section 6. Only this individual against all required databases, including Qualifier.net, determines that the individual can be a certifying official and would be allowed to participate in the Medicare program.

If multiple providers associated with one another, possessing separate OSCAR numbers, are making a change in provider-based status or applying for initial enrollment, a separate Form CMS-855A is required for each of them. However, the intermediary may review them concurrently (e.g., separate database checks are not required for individuals or entities shown in more than one application).

18 - Site Visits – (Rev. 29, 07-26-02)

In addition to the site visits required for all IDTF, DME and CMHC applicants (which have their own site visit instructions), contractors may conduct site visits for other applicants seeking enrollment in the Medicare program as well as to verify the status of currently enrolled providers. The purpose of the visit will be to verify the applicant's/supplier's compliance with applicable Medicare provider/supplier enrollment requirements. In general, site visits should be unannounced and the contractor representative(s) should always conduct themselves in a professional manner, disclosing to the applicant appropriate identifying credentials and explaining the purpose of the visit. The following are examples of some of the items that may be verified at the time of the site visit:

- The applicant has a physical business address where services can be rendered and the site is appropriate for the services being provided.
- The applicant has identified all of the practice locations where the applicant is providing services.
- The applicant has a place where patient medical records are maintained as required to process and make payment for Medicare claims.
- The applicant has the appropriate business and/or professional license(s) to provide specific services at all practice locations.
- The applicant has an appropriate number of qualified individuals to provide designated services.
- The applicant has all equipment necessary to provide designated services and all equipment is maintained in working condition.

The contractor will maintain records of applicant site visits to support decisions regarding the denial of a Medicare billing number, and the contractor will routinely analyze data to determine enrollment or other significant trends. Records will include actions taken regarding the disposition of the application, whether approved or denied; and any referral to other agencies for investigation or monitoring of fraud and/or abuse concerns, physical access issues, or health and safety concerns.

19 - Administrative Appeals – (Rev. 29, 07-26-02)

Carriers

Process for Physicians, Non-physician Practitioners, DMEPOS suppliers and Entities whose Medicare Enrollment Is Denied or Whose Billing Number Is Revoked.

A physician, non-physician practitioner, DMEPOS supplier or other entity, whose Medicare enrollment is denied or whose Medicare billing privilege is revoked, can request an appeal of that decision. This appeal procedure ensures that a physician, non-physician practitioner, DMEPOS supplier or entity that is not entitled to appeal rights under 42 CFR 498 receives a fair opportunity to be heard.

The appeals process can be found at 42 CFR 405.874. The administrative appeals process includes the right to a Medicare carrier hearing before a hearing officer who was not involved with the original carrier determination and the right to seek a review before an CMS official designated by the CMS Administrator.

If a Medicare carrier reviews the application and finds that a physician, non-physician practitioner, DMEPOS, or entity does not meet one or more of the requirements, the Medicare carrier denies the application and sends a denial letter explaining the reason for the denial to the physician, non-physician practitioner, DMEPOS supplier or entity. The letter explains the procedures for requesting a Medicare carrier hearing.

Similarly, when a Medicare carrier discovers that a physician, non-physician practitioner, DMEPOS supplier or entity no longer meets one of the requirements for a billing number, the physician's, non-physician practitioner's, DMEPOS supplier or entity's billing number is revoked. The carrier sends the physician, non-physician practitioner, DMEPOS supplier or entity a letter that explains that the billing number is revoked 15 days from the date the notice is mailed stating/ why the billing number is being revoked, and informs the physician, non-physician practitioner, DMEPOS supplier or entity of the procedures for requesting a hearing.

If a physician, non-physician practitioner, DMEPOS supplier or entity seeks review of the determination by filing a request for a carrier hearing, and there is a less than fully favorable decision by the hearing officer, the physician, non-physician practitioner, DMEPOS supplier or entity or the carrier may seek further review before an CMS official. The decision of the CMS official is the final administrative decision. An initial contractor determination, a decision of a

contractor hearing officer, or a decision of a CMS official may be reopened by the contractor or hearing officer in accordance with the procedures set forth at 42 CFR 405.84l and 405.842.

If, instead of filing or completing an appeal, a physician, non-physician practitioner, DMEPOS supplier or entity completes a corrective action plan and provides sufficient evidence to the carrier that it has complied fully with the Medicare requirements, the contractor may reinstate the physician's, non-physician practitioner's, DMEPOS supplier or entity's billing number. The contractor may pay for services furnished on or after the effective date of the reinstatement.

B. Contractor Hearing

A physician, non-physician practitioner, DMEPOS supplier or entity that wishes to request a contractor hearing, must file its request with the Medicare contractor within 60 days from the date of the receipt of the initial determination letter to be considered timely filed. The date the letter is received by the contractor is treated as the date of filing. Failure to timely request a contractor hearing is deemed a waiver of all rights to further administrative review. The request may be signed by the physician, non-physician practitioner, DMEPOS supplier or any responsible official within the entity.

If a timely request for a contractor hearing is made, a contractor hearing officer, not involved in the original determination to disallow a physician, non-physician practitioner, DMEPOS supplier or entity enrollment application, or to revoke a current billing number, must hold a hearing within 60 days of receipt of the appeal request, or later if requested by the physician, non-physician practitioner, DMEPOS supplier or entity. The physician, non-physician practitioner, DMEPOS, entity or the contractor may offer new evidence. The burden of persuasion is on the physician, non-physician practitioner, contractor or entity to show that its enrollment application was incorrectly disallowed or that the revocation of its billing number was incorrect. The contractor hearing officer's determination is based upon the information presented. The hearing is a thorough, independent review of the contractor's initial determination and the entire body of evidence, including any new information submitted. The contractor hearing can be held in person or by telephone at the physician's, non-physician practitioners, DMEPOS supplier or entity's request.

The hearing officer issues a written decision as soon as practicable after the hearing and forwards the decision by certified mail to CMS, the carrier, and the physician, non- physician practitioner, DMEPOS supplier or entity. The decision includes (i) information about the carrier's, physician's, non-physician practitioner's, DMEPOS supplier or entity's further right to appeal; (ii) the address to which the written appeal must be mailed; and (iii) the date by which the appeal must be filed (that is, 60 days after the date of receipt of the decision.)

A physician, non-physician practitioner, DMEPOS, contractor or entity may appeal the hearing officer's decision to CMS for a final administrative review within 60 days after the date of receipt of the hearing officer's decision. Failure to timely request the final administrative review by CMS is deemed a waiver of all rights to further administrative review. A contractor hearing officer's Partial or complete reversal of a carrier's initial determination is not implemented pending the contractor's decision to appeal the reversal to CMS, unless the contractor, in its sole discretion,

and without prejudice to its right to appeal, decides to implement the reversal pending an appeal. The contractor implements a reversal if it decides not to appeal a reversal to CMS, or the time to appeal expires. A contractor may implement a contractor hearing officer's Partial reversal even if the physician, non-physician practitioner, DMEPOS supplier or entity has appealed the Partial reversal to CMS, or the time for the physician, non-physician practitioner, DMEPOS supplier or entity to file an appeal has not expired.

C. Claims Submitted Following Revocation

If a contractor finds that payment to an organization or other entity is precluded under the reassignment statute and regulations, and the billing number is revoked, subsequent claims submitted by the reassignee following revocation will be rejected. The physician or non-physician practitioner that furnished the health care service can bill the Medicare program for payment in accordance with the applicable rules for submitting claims.

NOTE: CMS may take the appropriate steps to collect Medicare overpayments or pursue other appropriate legal remedies.

D. CMS Review

If a timely request for a final CMS administrative review of the contractor hearing officer's decision is made, a CMS official, designated by the Administrator of CMS, issues a decision based on the decision and the record established by the contractor hearing officer. The CMS official may supplement the record by requesting and obtaining any additional information from the contractor, physician, non-physician practitioner, DMEPOS supplier or entity. The CMS official's decision is (i) issued in writing as soon as practicable after the CMS official determines that there is sufficient information to decide the appeal (or that no additional information is forthcoming), unless the Party appealing the hearing officer's decision requests a delay; (ii) is forwarded by certified mail to the contractor and the physician, non-physician practitioner or entity; and (iii) contains information that no further administrative appeals are available. Any applicant or contractor who wishes to seek a hearing before a CMS official (after the final determination of a contractor official) should address this request to:

Kathleen Scully-Hayes
Office of Hearings
2520 Lord Baltimore Dr.
Suite L
Baltimore, MD 21244-2670

Appeal rights for prospective and existing providers can be found at 42 CFR §498 of the Medicare regulations. The regulation explains the appeal rights for certain prospective and existing providers following determinations by CMS as to whether such entities meet and/or continue to meet the requirements for enrollment in the Medicare program.

The contractor must assist the RO in the issuance of denials, and must provide and review information as requested by the RO concerning appeals of issued denials.

20 - Tracking Requirements – (Rev. 29, 07-26-02)

Once the Provider Enrollment, Chain, and Ownership System (PECOS) is operational, Medicare contractors will log in the entire application upon receipt. PECOS will respond to all tracking inquiries about the application, and the Medicare contractor responsible for the application can change an application's status as information is received. All others will have read-only access. Medicare contractors will continue to submit quarterly reports via the CROWD system to CMS. PECOS records will be available for daily and monthly statistical inquiries. Eight quarters of CROWD statistics will be reviewed for possible trends. The CROWD report is expected by April 15, July 15, October 15, and January 15. Refer to the MCM (CAR 3,13430) and the Intermediary Manual (INT 3 3898.17) for reporting instructions.

FIs will get a separate count for both Form CMS-855s submitted by the old and the new entity in the case of a CHOW, Acquisition/Merger, or Consolidation.

21 - Retention of Records – (Rev. 29, 07-26-02)

These instructions apply to documents relating to the enrollment of providers and suppliers into the Medicare program. These include, but are not limited to, Form CMS-855 enrollment forms and all supporting documents. Also included are attachments that are submitted with the application. These include but are not limited to:

- Copy(s) of Federal, state and/or local (city/county) professional licenses, certifications and/or registrations;
- Copy(s) of Federal, State, and/or local (city/county) business licenses, certification and/or registrations;
- Copy(s) of professional school degrees or certificates or evidence of qualifying course work;
- Copy(s) of curriculum vitae/resumes;
- Copy(s) of CLIA certificates and FDA mammography certificates;
- Copy(s) of controlled substances registrations from the Drug Enforcement Agency; and
- Copy(s) of CO letter issuing an indirect billing number to a managed care organization or plan.

CMS contractors must dispose of the aforementioned records as described below:

1) Application is pending--destroy after a retention period of seven years.

2) Application is approved--retain for as long as the provider is enrolled. After enrollment has ended, retain for 15 years.

3) Application is denied--destroy after a retention period of 15 years after the denial.

4) Application is approved--but subsequently, the billing number is revoked--retain for 15 years.

5) Voluntary deactivation of billing number--destroy after a retention period of 15 years.

6) Provider/Supplier dies--destroy after a retention period of 7 years.

22 - Provider/Supplier Education – (Rev. 29, 07-26-02)

One of the functions that must be carried out is providing training and education to Medicare physicians and other healthcare providers and suppliers. This should be done in conjunction with Provider Education and Training (PET) or Professional Relations unit. The PET program will use various media such as print, Internet, and in-person presentations in classrooms and other settings to provide timely, accurate and understandable Medicare information. There may also be a requirement to Partner with external entities and the publication of written materials other than newsletters and bulletins.

23 - Web Site – (Rev. 41, 05-23-03)

Contractors must provide a link to CMS' provider/supplier enrollment Web site located at http://www.cms.hhs.gov/providers/enrollment/. Make the link available on the contractor's existing provider outreach Web site (which should be an established subdomain of the contractor's current commercial Web site) and it must comply with the guidelines stated in the Provider/Supplier Information and Education Web site section– (Activity Code 14101) under the Provider Communications (PCOM) Budget and Performance Requirements (BPRs). Bulletins, newsletters, seminars/workshops and other information concerning provider enrollment issues should also be made available on the existing provider outreach Web site.

The CMS Provider/Supplier Enrollment Web site, http://www.cms.hhs.gov/providers/enrollment/, furnishes the user with access to provider/supplier enrollment forms, specific requirements for provider/supplier types, manual instructions, troubleshooting, contact information, hot topics, and other pertinent provider/supplier information. Do not duplicate content already provided at the CMS provider/supplier enrollment Web site. Do not reproduce the forms or establish the contractor's own links to forms. Link directly to the forms section of the CMS provider/supplier enrollment site at http://www.cms.hhs.gov/providers/enrollment/forms/.

Contractors must review, for accuracy, the areas of their respective Web sites that pertain to Provider Enrollment. This is imperative because Web sites that contain the CMS logo, as do most contractor Web sites, should contain useable, accurate and current information in accordance with the agency's initiative. *Further, contractor Web sites must comply with Section 508 of the Rehabilitation Act of 1973 in accordance with the Code of Federal Regulations, 36 CFR §1194 and must comply with CMS' Contractor Web site Standards and Guidelines posted at*

http://www.cms.hhs.gov/about/web/contractors.asp. To learn more about Section 508 requirements and to obtain guidance, refer to http://www.cms.hhs.gov/about/web/section508/.

Quarterly, each contractor must review and provide updates regarding their information that we show at URL: http://www.cms.hhs.gov/providers/enrollment/contacts/. If you are a contractor that services several states with a universal address and telephone number, please report that information. In situations where no actions are required, a response from the contractor is still required (i.e. "our contact information is accurate"). In addition, only information that pertains to Provider Enrollment activity for the contractor's jurisdiction is to be reported.

Send updates directly to the RO contact that services the contractor's geographical area. The RO contact will forward this information to the CO Webmaster.

24 - Security Safeguards – (Rev. 29, 07-26-02)

Provider enrollment staff must meet all requirements as defined in the CMS/Business Partners Systems Security Manual and its appendices. Additionally, the provider enrollment staff must control and monitor all applications accessed by other contractor personnel with a need to know, e.g., auditors reviewing cost reports, review by Benefit Integrity/PSC or the electronic funds transfer unit. Applications must never be removed from the area to be worked on at home.

25 - Documentation – (Rev. 41, 05-23-03)

To ensure that proper internal controls are maintained and that important information is recorded in case of potential litigation, the contractor must provide documentation in the following situations. Please note that the requirements listed below are in addition to, and not in lieu of, all other documentation or document maintenance requirements mandated by CMS. For instance, the contractor must retain copies of all written correspondence (including e-mails and faxes) pertaining to the provider/supplier, regardless of whether the correspondence was initiated by the contractor, the provider/supplier, state officials, etc.

Verification of Data Elements

1. Once the contractor have completed its review of the application (i.e., approved/denied application, made recommendation for approval/denial, finished processing a change request, etc.), the contractor must provide a written statement asserting that it has: (1) Verified all data elements on the application, and (2) Reviewed all applicable names on Form CMS-855 against Qualifier.net (for MED and GSA data), FID and HIPDB databases. This statement must be signed and dated. The statement can be drafted in any manner the contractor chooses so long as it certifies that the above-mentioned activities were completed. Place the statement in the provider file when completed. *The contractor must keep a record of all verifications performed. This record can be stored electronically, if the contractor can provide access to the data verifications within 24 hours upon request. Data verifications performed through the use of PECOS do not require separate records.*

2. For each person and/or entity that appeared on the FID, HIPDB, MED, and/or GSA lists, document the following:

- The name of the person;
- The date on which the person/entity was checked against each database; and
- The findings of the review.

The findings of the review can be documented via a print screen, a document obtained from Qualifier.net, or any file that confirms the action of an application be denied. Also document what the findings were (e.g., type and date of exclusion, etc.). Please note that if an individual/entity appears on any of the three databases, document the search results for the other databases as well. For instance, if Joe Smith appeared on the FID, document the above-bulleted information concerning its review of Qualifier.net for Joe Smith. In addition, provide the written statement outlined in Paragraph 1.

Telephonic and Face-to-Face Contact

The contractor must document any telephone contact with the provider/supplier, any representative thereof, or any other person regarding a provider/supplier. In addition, document any face-to-face conversation with the provider/supplier or any of its representatives. This includes, but is not limited to, situations that would result in a change to the application. Examples include:

- Contacting Benefit Integrity/PSC personnel for an update concerning an application sent to them;
- Telephoning an individual practitioner concerning a request for additional information;
- Requesting information from the state or another contractor concerning the applicant or enrollee;
- Contacting the CMS RO concerning a problem the contractor is having with an applicant or an existing provider/supplier; and
- Conducting a meeting at headquarters/offices with officials from an enrolling hospital concerning serious problems with its application.

The contractor's documentation must indicate: (1) The time and date of the call or contact, (2) Who initiated contact, (3) Who was spoken with, and (4) What the conversation pertained to. Concerning the last requirement, the contractor need not write down every word that was said during the conversation. Rather, the documentation should merely be adequate to reflect the contents of the conversation. *The documentation can be stored electronically, if the contractor can provide access within 24 hours upon request.*

Please note that the documentation requirements listed above apply to previously enrolled providers/suppliers and any person/entity who has already submitted an application to be enrolled. In other words, the documentation requirement only is required after the enrollee submits an initial application. For instance, if a hospital contacts the contractor requesting information concerning how it should enroll in the Medicare program, this need not be documented because the hospital has not yet submitted an enrollment application.

26 – File Maintenance and Review – (Rev. 41, 05-23-03)

All files should be organized and maintained utilizing a contractor consistent method that shall enable a person knowledgeable with provider enrollment to expeditiously ascertain the following:

1. *Where is the completed Form CMS-855 and which pages (if any) have been corrected, added or changed.*

2. *What information or clarifications were asked of the applicant or enrollee by the contractor. This includes the when and how for such information.*

3. *For intermediaries only – If the applicant has checked the wrong box in block 1A1 of the Form CMS-855A, or the transaction taking place is not easily determined by a reviewer, the file shall clearly state the type of transaction being processed.*

File review – For intermediaries only. At least once a year the contractor shall perform an internal review of at least one enrollment file processed within the past year. The review shall be documented and cite any problematic findings, if any. The review should be based upon the principles of this Program Integrity Manual, Chapter 10 and check for documentation and organization of the file.