

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Centers for Medicare & Medicaid Services



**News Flash** – The Centers for Medicare and Medicaid Services (CMS) will be conducting follow-up calls to providers regarding the Comprehensive Error Rate Testing (CERT) program. CMS staff may contact you to obtain all necessary medical record documentation for claims reviewed under the CERT program. Although you may have already received letters and telephone calls from the CERT contractor, these additional efforts by CMS to obtain adequate documentation may change your claim's status from "improper payment" to "proper payment." This will allow CMS to calculate a more accurate Medicare Fee-For-Service error rate, while also reducing the amount of improper payments.

MLN Matters® Number: MM7232

Related Change Request (CR) #: 7232

Related CR Release Date: March 25, 2011

Effective Date: October 1, 2010

Related CR Transmittal #: R372PI

Implementation Date: April 25, 2011

## Effective Date of Certified Provider or Supplier Agreement or Approval

### Provider Types Affected

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This article is for providers and suppliers subject to survey and certification requirements.

### Provider Action Needed

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#### **STOP – Impact to You**

This article is based on Change Request (CR) 7232 which clarifies instructions regarding the determination of the effective date of certified provider agreement or supplier approval.



#### **CAUTION – What You Need to Know**

The Code of Federal Regulations (42 CFR 489.13) has been revised to make it clearer that the date of a Medicare provider agreement or supplier approval may not

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be earlier than the latest date on which all applicable federal requirements have been met, and that such requirements include review and verification of an application to enroll in the Medicare program by the Centers for Medicare & Medicaid Services (CMS) legacy fiscal intermediary (FI), legacy carrier, or Medicare Administrative Contractor (MAC).



### GO – What You Need to Do

See the Background and Additional Information Sections of this article for further details regarding these changes.

## Background

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The Fiscal Year (FY) 2011 Inpatient Prospective Payment System (IPPS) final rule was published on August 16, 2010 (75 FR50042) and was effective October 1, 2010 (see the FY 2011 IPPS final rule at <http://edocket.access.gpo.gov/2010/2010-19092.htm> on the Internet). Several provisions in the FY 2011 IPPS final rule amend Section 489.13 of the Code of Federal Regulations (42 CFR 489.13) which governs the determination of the effective date of a Medicare provider agreement or supplier approval for health care facilities that are subject to survey and certification. The revised Section 489.13 makes it clearer that:

- The date of a Medicare provider agreement or supplier approval may not be earlier than the latest date on which all applicable federal requirements have been met; and
- Such requirements include review and verification of an application to enroll in the Medicare program by the CMS legacy fiscal intermediary (FI), legacy carrier, Regional Home Health Intermediary (RHHI), or Medicare Administrative Contractor (MAC).

You can review revised 489.13 of the CFR at <http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr;sid=cbe4615ac0d1730fe7871c78553897f9;rgn=div2;view=text;node=20100816%3A1.77;idno=42;cc=ecfr;start=1;size=25> on the Internet.

These clarifications were necessary because a September 28, 2009, decision of the Appellate Division of the Departmental Appeals Board (DAB) interpreted Section 489.13 as not including enrollment application processing among Federal requirements that must be met. You can review the DAB Decision No. 2271 at <http://www.hhs.gov/dab/decisions/dabdecisions/dab2271.pdf> on the Internet.

In that case a State Agency had:

- Conducted a survey of an applicant on July 6, 2007; and
- Received the FI's notice on November 21, 2007, recommending the applicant's enrollment approval.

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The CMS Regional Office (RO) issued a provider approval effective November 21, 2007 (the date the FI recommended the applicant's enrollment approval), consistent with our traditional interpretation of Section 489.13. However, the DAB ruled that the effective date must be July 6, 2007 (the date the survey was conducted).

The DAB agreed with the applicant in this case that the requirement for the Medicare contractor to verify and determine whether an application should be approved is

- Not a requirement for the provider to meet (under Section 489.13), but rather
- A requirement for Medicare contractor action (DAB Decision No. 2271, page 5).

In accordance with Section 2003B of the State Operations Manual (SOM), State Agencies and accreditation organizations are aware that they should **perform a survey of a new facility after** the MAC/legacy FI/legacy carrier has provided notice that:

- The information on the enrollment application has been verified, and
- Enrollment is being recommended.

However, circumstances do occur when the sequence is reversed, i.e. the survey occurs prior to enrollment verification activities. Accreditation organizations, in particular, often find it challenging to confirm whether the MAC, FI, RHHI, or carrier has completed its review and made a recommendation, since they are dependent upon the applicant providing copies of the pertinent notices.

When the survey occurs prior to the enrollment verification activities, CMS believes it is essential that the provider agreement or supplier approval date be based on the later date, i.e., the date the contractor determined that the enrollment application was verified and recommends approval.

There are other Federal requirements not related to a facility's survey, such as the provision of required Office for Civil Rights documentation. Accordingly, the revised rule explicitly states in Section 489.13(b) that:

**"Federal requirements include, but are not limited to –**

- (1) Enrollment requirements established in part 424, Subpart P, of this chapter. CMS determines, based upon its review and verification of the prospective provider's or supplier's enrollment application, the date on which enrollment requirements have been met;**
- (2) The requirements identified in (Sections) 489.10 and 489.12; and**
- (3) The applicable Medicare health and safety standards, such as the applicable conditions of participation, the requirements for participation, the conditions for coverage, or the conditions for certification.**

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## Additional Information

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The official instruction, CR 7232, issued to your carriers, FIs, MACs, and RHHIs regarding this change may be viewed at <http://www.cms.gov/transmittals/downloads/R372PI.pdf> on the CMS website.

If you have any questions, please contact your carriers, FIs, A/B MACs, or RHHIs at their toll-free number, which may be found at <http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

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