

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



News Flash – Medicare is denying an increasing number of claims, because providers are not identifying the correct primary payer prior to claims submission. Medicare would like to remind providers, physicians, and suppliers that they have the responsibility to bill correctly and to ensure claims are submitted to the appropriate primary payer. Please refer to the [“Medicare Secondary Payer \(MSP\) Manual,” Chapter 3](#), and [MLN Matters® Article SE1217](#) for additional guidance.

MLN Matters® Number: MM7797

Related Change Request (CR) #: CR 7797

Related CR Release Date: April 13, 2012

Effective Date: May 14, 2012

Related CR Transmittal #: R415PI

Implementation Date: May 14, 2012

General Update to Chapter 15 of the Program Integrity Manual (PIM) Part V

Provider Types Affected

This MLN Matters® Article is intended for physicians, providers, and suppliers that submit claims to Medicare Carriers, Fiscal Intermediaries (FIs), Part A/B Medicare Administrative Contractors (A/B MACs) and Home Health & Hospice Medicare Administrative Contractors (HHH MACs) for services provided to Medicare beneficiaries.

What You Need to Know

This article is based on Change Request (CR) 7797, which implements changes to Chapter 15 of the Program Integrity Manual (PIM)—Medicare Enrollment. CR7797 focuses on the reasons for returning CMS-855 applications in Section 15.8.1 and the policies for rejecting CMS-855 applications in Section 15.8.2 of the PIM. Please make sure your staff is familiar with these changes.

Key Points

Providers and suppliers who bill Medicare Carriers, FIs, A/B MACs and HHH MACs should take note of the following:

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- Your Medicare contractor may return a Form CMS-855 submission only in the following instances:
 - The applicant sent its paper Form CMS-855 to the wrong contractor;
 - The contractor received the application more than 60 days prior to the effective date listed on the application (though this does not apply to: (a) providers and suppliers submitting a Form CMS-855A application, (b) Ambulatory Surgical Centers (ASCs), or (c) Portable X-ray Suppliers (PXRSS));
 - The contractor received an initial application from (a) a provider or supplier submitting a Form CMS-855A application, (b) an ASC, or (c) a PXRSS, more than 180 days prior to the effective date listed on the application;
 - An old owner or new owner in a Change of Ownership (CHOW) submitted its application more than 90 days prior to the anticipated date of the sale (though this only applies to Form CMS-855A applications);
 - The contractor can confirm that the provider or supplier submitted an initial enrollment application prior to the expiration of the time period in which it is entitled to appeal the denial of its previously submitted application;
 - The provider or supplier submitted an initial application prior to the expiration of a re-enrollment bar; and/or
 - The application is not needed for the transaction in question.

Providers and suppliers who bill Medicare Carriers and A/B MACs take note of the following:

- If, under Section 15.8.2 of Chapter 15, a physician, non-physician practitioner, or physician or non-physician practitioner group fails to provide requested information regarding its Form CMS-855 submission within the designated timeframe, the contractor will reject (rather than deny) the application.

Additional Information

The official instruction, CR7797, issued to your Medicare Carrier, FI, RHHI, or A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R415PI.pdf> on the CMS website. Attached to CR7797 is the revised PIM Chapter, which further details the reasons for return/rejection.

If you have any questions, please contact your carrier, FI, RHHI, or A/B MAC 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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