

CMS Guidance Document	Department of Health & Human Services (DHHS)
Pub. 100-08 Program Integrity Manual	Centers for Medicare & Medicaid Services (CMS)
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PROGRAM AREA: Provider Enrollment-Fee for Service

SUBJECT: Provider Enrollment Manual Update

APPLIES TO: Contractors

I. SUMMARY OF DOCUMENT: This is the first of several partial updates to Publication 100-08, chapter 10. It more or less covers the initial one-fifth of chapter 10. Most of the changes are editorial in nature, though more substantive matters are addressed as well.

II. CHANGES IN POLICY INSTRUCTIONS: (If not applicable, indicate N/A)

STATUS: R=REVISED, N=NEW, D=DELETED.

Status	Chapter / Section / Subsection / Title
R	10/Table of Contents
R	10/1/Introduction to Provider Enrollment
R	10/1.1/Definitions
R	10/1.2/CMS-855 Medicare Enrollment Applications
R	10/2.1/Timeframes for Initial Applications
R	10/2.2/Timeframes for Changes of Information
R	10/2.3/General Timeliness Principles
R	10/3.2/Returning the Application
R	10/4.1/Basic Information (Section 1 of the CMS-855)
R	10/4.2.1/Employer Identification Numbers and Legal Business Names
R	10/4.2.2/Licenses and Certifications
R	10/4.2.3/Correspondence Address
R	10/4.2.4/Accreditation
R	10/4.2.5/Section 2 of the CMS-855A
R	10/4.2.6/Section 2 of the CMS-855B
R	10/4.2.7/Section 2 of the CMS-855I
R	10/4.3/Adverse Legal Actions/Convictions

R	10/4.4/Practice Location Information
R	10/4.4.1/Section 4 of the CMS-855A
R	10/4.4.2/Section 4 of the CMS-855B
R	10/4.4.3/Section 4 of the CMS-855I
R	10/4.13/Contact Person
R	10/12.1.6/Home Health Agencies (HHAs)
R	10/18.2/Provider Enrollment Inquiries

III. CLEARANCES:

Clearance & Point of Contact (POC)	Name/Telephone/Component
Senior Official Clearance	Kimberly Brandt (410) 786-5704/Office of Financial Management (OFM)
Agency POC	Frank Whelan, (410) 786-1302 Frank.whelan@cms.hhs.gov

IV. TYPE (Check appropriate boxes for type of guidance)

	Audit Guide
X	Change Request
	HPMS
	Joint Signature Memorandum/Technical Director Letter
	Manual Transmittal/Non-Change Request
	State Medicaid Director Letters
	Other

V. STATUTORY OR REGULATORY AUTHORITY: N/A

Attachment - Business Requirements

Pub. 100-08	Transmittal:	Date:	Change Request: 5671
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SUBJECT: Provider Enrollment Manual Update

EFFECTIVE DATE: OCTOBER 1, 2007

IMPLEMENTATION DATE: OCTOBER 1, 2007

I. GENERAL INFORMATION

A. Background: This change request provides a partial update to Publication 100-08, chapter 10. While most of the changes are editorial in nature, more substantive matters are addressed as well, including: (1) the distinction between the correspondence address and the contact person, and (2) the enrollment of transplant centers.

B. Policy: The purpose of this change request is to ensure that chapter 10 is regularly updated as new policies are developed and existing policies are revised.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A / B M A C	D M E M A C	F I	C A R R I E R	D M E R C	R H I	Shared-System Maintainers				OTHER
								F I S S	M C S	V M S	C W F	
5671.1	While the contractor should use the contact person listed in section 13 of the CMS-855 for all communications specifically related to the provider's submission of a CMS-855 initial enrollment, change of information request, etc., the contractor shall direct all other provider enrollment-oriented matters to the provider's correspondence address.	X		X	X		X					
5671.1.1	It is strongly recommended that the contractor send all approval/denial letters to the contact person listed in section 13 of the CMS-855.	X		X	X		X					
5671.1.2	The contractor shall use its discretion to determine whether a particular communication is "specifically related" to a CMS-855 submission or is "provider enrollment-oriented."	X		X	X		X					
5671.2	If a hospital wishes to add a transplant center, the contractor shall ensure that the provider checks the "other" box in section 2A2 of the CMS-855A, writes "transplant center" on the space provided, and	X		X			X					

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A / B M A C	D M E M A C	F I	C A R R I E R	D M E R C	R H H I	Shared-System Maintainers				OTHER
								F I S S	M C S	V M S	C W F	
	follows the standard instructions for adding a sub-unit.											
5671.2.1	The contractor shall process the CMS-855A in the same manner it would process the addition of a hospital sub-unit; however, no separate enrollment record in PECOS need be created for the transplant center.	X		X			X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A / B M A C	D M E M A C	F I	C A R R I E R	D M E R C	R H H I	Shared-System Maintainers				OTHER
								F I S S	M C S	V M S	C W F	
	None.											

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below:

Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
N/A	

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

V. CONTACTS

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

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

VI. FUNDING

A. For Fiscal Intermediaries, Carriers, and the Durable Medical Equipment Regional Carrier (DMERC): No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.

B. For Medicare Administrative Contractors (MAC): The contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the Statement of Work (SOW). The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Medicare Program Integrity Manual

Chapter 10 - Medicare Provider Enrollment

Table of Contents

(Rev.)

4.2.1 - *Employer* Identification Numbers and Legal Business Names

1 – Introduction to Provider Enrollment

(Rev.)

This chapter specifies the resources and procedures Medicare fee-for-service contractors must use to establish and maintain provider and supplier enrollment in the Medicare program. These procedures apply to carriers, fiscal intermediaries, Medicare administrative contractors and the National Supplier Clearinghouse (*NSC*), unless contract specifications state otherwise.

No provider or supplier shall receive payment for services furnished to a Medicare beneficiary unless the provider or supplier is enrolled in the Medicare program. Further, it is essential that each provider and supplier enroll with the appropriate Medicare fee-for-service contractor.

1.1 – Definitions

(Rev.)

Below is a list of terms commonly used in the Medicare enrollment process:

Applicant means the individual (practitioner/supplier) or organization who is seeking enrollment into the Medicare program.

Approve/Approval means the enrolling provider or supplier has been determined to be eligible under Medicare rules and regulations to receive a Medicare billing number and be granted Medicare billing privileges.

Authorized Official means an appointed official (e.g., chief executive officer, chief financial officer, general partner, chairman of the board, or direct owner) to whom the organization has granted the legal authority to enroll it in the Medicare program, to make changes or updates to the organization's status in the Medicare program, and to commit the organization to fully abide by the statutes, regulations, and program instructions of the Medicare program.

Billing Agency means a company that the applicant contracts with to prepare, edit and/or submit claims on its behalf.

Change of Ownership (CHOW) is defined in 42 CFR § 489.18 (a) and generally means, in the case of a partnership, the removal, addition, or substitution of a partner, unless the partners expressly agree otherwise, as permitted by applicable State law. In the case of a corporation, the term generally means the merger of the provider corporation into another corporation, or the consolidation of two or more corporations, resulting in the creation of a new corporation. The transfer of corporate stock or the merger of another corporation into the provider corporation does not constitute *a* change of ownership.

Deactivate means that the provider or supplier's billing privileges were stopped, but can be restored upon the submission of updated information.

Delegated Official means an individual who is delegated by the "Authorized Official," the authority to report changes and updates to the enrollment record. The delegated official must be an individual with an ownership or control interest in (as that term is defined in section 1124(a)(3) of the Social Security Act), or be a W-2 managing employee of, the provider or supplier.

Deny/Denial means the enrolling provider or supplier has been determined to be ineligible to receive Medicare billing privileges for Medicare covered items or services provided to Medicare beneficiaries.

Enroll/Enrollment means the process that Medicare uses to establish eligibility to submit claims for Medicare covered services and supplies. The process includes:

- Identification of a provider or supplier;
- Validation of the provider or supplier's eligibility to provide items or services to Medicare beneficiaries;
- Identification and confirmation of the provider or supplier's practice locations and owners; *and*
- Granting the provider or supplier Medicare billing privileges.

Enrollment Application means a CMS-approved paper enrollment application or an electronic Medicare enrollment process approved by the Office of Management and Budget (*OMB*).

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

Managing Employee means a general manager, business manager, administrator, director, or other individual that exercises operational or managerial control over, or who directly or indirectly conducts, the day-to-day operation of the provider or supplier, either under contract or through some other arrangement, whether or not the individual is a W-2 employee of the provider or supplier.

Medicare Identification Number is the generic term for any number, other than the National Provider Identifier, used by a provider or supplier to bill the Medicare program.

(For Part A providers, the Medicare Identification Number (MIN) is the CMS Certification Number (CCN). For Part B suppliers other than suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS), the MIN is the Provider Identification Number (PIN). For DMEPOS suppliers, the MIN is the number issued to the supplier by the NSC.)

National Provider Identifier is the standard unique health identifier for health care providers (including Medicare suppliers) and is assigned by the National Plan and Provider Enumeration System (NPPES).

Operational means the provider or supplier has a qualified physical practice location, is open to the public for the purpose of providing health care related services, is prepared to submit valid Medicare claims; and is properly staffed, equipped, and stocked (as applicable, based on the type of facility or organization, provider or supplier specialty, or the services or items being rendered) to furnish these items or services.

Owner means any individual or entity that has any partnership interest in, or that has 5 percent or more direct or indirect ownership of, the provider or supplier as defined in sections 1124 and 1124(A) of the Social Security Act.

Provider is defined at 42 CFR § 400.202 and generally means a hospital, critical access hospital, skilled nursing facility, comprehensive outpatient rehabilitation *facility*, home health agency or hospice, that has in effect an agreement to participate in Medicare; or a clinic, rehabilitation agency, or public health agency that has in effect a similar agreement but only to furnish outpatient physical therapy or speech pathology services; or *a* community mental health center that has in effect a similar agreement but only to furnish partial hospitalization services.

Reassignment means that an individual physician or non-physician practitioner, except physician assistants, has granted a clinic or group practice the right to receive payment for the practitioner's services.

Reject/Rejected means that the provider or supplier's enrollment application was not processed due to incomplete information or that additional information or corrected information was not received from the provider or supplier in a timely manner.

Revoke/Revocation means that the provider or supplier's billing privileges are terminated.

Supplier is defined in 42 CFR § 400.202 and means a physician or other practitioner, or an entity other than a provider that furnishes health care services under Medicare.

Tax Identification Number means the number (either the Social Security Number (SSN) or Employer Identification Number (EIN)) the individual or organization uses to report tax information to the IRS.

1.2 – CMS-855 Medicare Enrollment Applications **(Rev.)**

The Medicare enrollment applications (CMS-855I, CMS-855R, CMS-855B, CMS-855A and CMS-855S) are forms issued by CMS and approved by *OMB*. The forms collect general information about providers, suppliers, *and DMEPOS suppliers* in order to:

- Ensure that the applicant is qualified and eligible to enroll in the Medicare program.
- Help determine the proper amount of Medicare payment.

The five forms are distinguished as follows:

- CMS-855I - This form *should* be completed by *individual practitioners, including physicians and non-physician practitioners*, who *render* Medicare Part B services to Medicare beneficiaries. (This includes a physician or practitioner who: (1) is the sole owner of a professional corporation, professional association, or limited liability company, and (2) will bill Medicare through this business entity.)
- CMS-855R - An individual who renders Medicare Part B services and seeks to reassign his or her benefits to an eligible entity *should* complete this form for each entity eligible to receive reassigned benefits. The person must be enrolled in the Medicare program as an individual prior to reassigning his or her benefits.
- CMS-855B - This application *should* be completed by a supplier organization (e.g., ambulance company) that will bill Medicare for Part B services furnished to Medicare beneficiaries. It is not used to enroll individuals.
- CMS-855A - This application *should* be completed by *institutional* providers (e.g., hospital) that will furnish Medicare Part A services to Medicare beneficiaries.
- CMS-855S – *This application should be completed by DMEPOS suppliers*. The *NSC* is responsible for processing *this type of enrollment* application.

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.

When a prospective provider or supplier contacts the contractor to obtain a CMS-855 application, the contractor shall furnish:

- The *CMS* Web site at which the applications can be accessed (www.cms.hhs.gov/MedicareProviderSupEnroll);
- Notification of any *supporting* documentation required for the applicant's provider/supplier type;
- *The Electronic Funds Transfer Authorization Agreement (CMS-588)*;

- The Electronic Data Interchange (EDI) agreement;
- The Medicare Participating Physician or Supplier Agreement (*CMS-460*), with *an explanation of* the purpose of the agreement and how it differs from the actual enrollment process. (This only applies to carriers.)
- The contractor's address, so that the applicant knows where to return the completed application;
- If the applicant is a certified supplier or provider, notification that the applicant should contact the State agency for any state-specific forms and to begin preparations for a State survey. (This does not apply for those certified entities, such as FQHCs, that do not receive a State survey.) The notification can be given in any manner the contractor chooses.

2.1 – Timeframes for Initial Applications

(Rev.)

The contractor shall process 80 percent of *CMS-855* applications within 60 calendar days of receipt, process 90 percent of CMS-855 applications within 120 calendar days of receipt, and process 99 percent of CMS-855 applications within 180 calendar days of receipt. This process generally includes:

- Receipt of the application in the contractor’s mailroom and forwarding it to the appropriate office for review;
- Prescreening the application in accordance with section 3.1 of this manual;
- Creating an L & T record and an enrollment record in PECOS;
- Verification of the application in accordance with sections 5.1 through 5.7 of this manual;
- Requesting and receiving clarifying information in accordance with section 5.3 of this manual;
- Supplier site visit (if necessary);
- Formal notification of the contractor’s decision or recommendation (and providing the appropriate appeal rights, as necessary) for approval or denial.

For purposes of timeliness, the term “initial applications” also includes:

1. CHOW, acquisition/merger, and consolidation applications submitted by the new owner;
2. “Complete” CMS-855 applications submitted by enrolled providers: *(a) voluntarily, (b) as part of any change request if the provider does not have an established enrollment record in PECOS, (c) as part of a reactivation, or (d) as part of a revalidation.* (See sections 5.7 *and* 7.1.1 of this manual for more information on the processing of “complete” applications.)

2.2 – Timeframes for Changes of Information

(Rev.)

The contractor shall process 80 percent of CMS-855 change of information applications within 45 calendar days of receipt, process 90 percent of such applications within 60 calendar days of receipt, and process 99 percent of such applications within 90 calendar days of receipt. This process generally includes:

- Receipt of the change request in the contractor’s mailroom and forwarding it to the appropriate office for review;
- Prescreening the change request in accordance with section 3.1 of this manual;
- Creating an L & T record and, if applicable, tying it to an enrollment record in PECOS;
- Verification of the change request in accordance with sections 5.1 through 5.7 of this manual, as well as the applicable instructions in sections 7.1 and 7.2 of this manual;
- Requesting and receiving clarifying information in accordance with section 5.3 of this manual;
- Supplier site visit (if necessary);
- Formal notification of the contractor’s decision or recommendation (and providing the appropriate appeal rights, as necessary) for approval or *denial*.

For purposes of timeliness, the term “changes of information” also includes:

1. CHOW, acquisition/merger, and consolidation applications submitted by the old owner;
2. CMS-588 changes submitted without a need for an accompanying *complete* CMS-855 application;
3. CMS-855R applications submitted independently (i.e., without being part of a *CMS-855I* or CMS-855B package);
4. CMS-855 voluntary terminations.

2.3 - General Timeliness Principles *(Rev.)*

Unless stated otherwise, the principles discussed below apply to all applications discussed in section 2.1 and 2.2 above (e.g., CHOW applications submitted by old and new owners, CMS-588 forms).

A. Clock Stoppages

The processing time clocks identified in sections 2.1 and 2.2 of this manual cannot be stopped or suspended for any reason. This includes, but is not limited to, the following situations:

- Referring an application to the *OIG or the* Payment Safeguard Contractor (*PSC*);
- Waiting for the final sales agreement (e.g., CHOW, acquisition/merger);
- Waiting for the RO to make a provider-based, HHA capitalization, or CHOW determination;
- Referring a provider to the Social Security Administration (SSA) to resolve a discrepancy involving a social security number (SSN), as explained in section 4.2.1 of this manual.
- Contacting CO (e.g., DPSE) or an RO's survey/certification staff with a question regarding the application in question or CMS policy.

Despite the prohibition on clock stoppages and suspensions, the contractor should always document any delays by identifying when the referral to CMS, *the OIG*, etc., was made, the reason for the referral, and when a response was received. By doing so, the contractor will be able to furnish explanatory documentation to CMS should applicable time limits be exceeded. *To illustrate*, assume a contractor received an initial CMS-855B application on March 1. On March 30, the contractor sent an adverse legal action question to CMS, and received a reply on April 7. The processing time clock did not stop from March 31 to April 7. However, the contractor should document its files to explain that it forwarded the question to CMS, the dates involved, and the reason for the referral.

B. Calendar Days

Unless otherwise stated in this manual, all days in the processing time clock are “calendar” days, not “business days.” If the 60th day (for initials) or 45th day (for changes of information) falls on a weekend or holiday, this is still the day by which the application must be processed. If the contractor is unable to finish processing the application until the next business day, however, it should document the file that the 60th day fell on a Saturday/Sunday/holiday and furnish any additional explanation as needed.

C. Date-Stamping

As a general rule, all incoming correspondence must be date-stamped on the date it was received in the contractor's mailroom. This includes, but is not limited to:

- Any CMS-855 application, including initials, changes, CHOWs, etc. (The first page of the application must be date-stamped.)
- Letters from providers. (The first page of the letter must be date-stamped.)
- Supporting documentation, such as licenses, certifications, articles of incorporation, and billing agreements. (The first page of the document or the envelope must be date-*stamped*.)

- *Data* furnished by the provider (*via mail or fax*) per the contractor's request for additional information. (All submitted pages must be date-stamped. This is because many contractors interleaf the new/changed pages within the original application; hence, it is necessary to determine the sequence in which the application and the additional pages were received.)

The timeliness clocks discussed in sections 2.1 and 2.2 above start on the *date the* application/envelope is date-stamped in the contractor's mailroom, not when the application is date-stamped or received by the provider enrollment unit. As such, the date-stamping activities described in the aforementioned bullets must be performed in the contractor's mailroom. In cases where the mailroom staff fails to date-stamp a particular document, the provider enrollment unit may date-stamp the page in question. However, there shall not be long lapses between the time it was received in the mailroom and the time the provider enrollment unit *date-stamped* the pages.

In addition, *and* unless stated otherwise in this manual *or other CMS directive*, all incoming enrollment applications (including change requests) must be submitted via mail.

D. When the Processing Cycle Ends

For: (1) fiscal intermediaries, and (2) carriers processing ASC or portable x-ray applications, the processing cycle ends on the date the contractor sends its recommendation for approval or denial to the State agency. In situations involving a change request that does not require a recommendation (i.e., it need not be forwarded to and approved by the State or RO), the cycle ends on the date the contractor sends notification to the provider that the change has been processed. If notification to the provider is made via telephone, the cycle ends on the date the telephone call is made (e.g., the date the voice mail message is left).

For carriers processing applications other than those from ASCs and portable x-ray suppliers, the processing cycle ends on the date the carrier sends its approval/denial letter to the supplier. For change request approval/denial notifications made via telephone, the cycle ends on the date the telephone call is made (e.g., the date the voice mail message is left).

For any application that is rejected per section 3.1 or 5.3 of this manual, the processing time clock ends on the date the contractor sends notification to the provider that the application has been rejected.

E. PECOS

Unless stated otherwise in this manual, the contractor must create an L & T record in PECOS no later than 15 calendar days after its receipt of the provider's application in the contractor's mailroom. *Moreover*, the contractor must establish a complete enrollment record in PECOS – if applicable - prior to its approval or denial of (or recommendation of

approval or denial of) the provider's application; to the maximum extent possible, the contractor shall establish the enrollment record at one time, rather than on a piecemeal basis.

The L & T and enrollment record requirements in the previous paragraph apply to all applications identified in sections 2.1 and 2.2 above (e.g., reassignments, CHOW applications submitted by old and new owners).

In situations where the contractor cannot create an L & T record within 15 days due to missing information (e.g., no NPI was furnished), the contractor shall document the provider file accordingly.

3.2 – Returning the Application

(Rev.)

A. Immediate Returns

The contractor shall immediately return the enrollment application to the provider in the instances described below. This policy applies to all applications identified in sections 2.1 and 2.2 of this manual:

- There is no signature on the CMS-855 application;
- The provider submits the 11/2001 version of the CMS-855 application;
- The application contains a copied or stamped signature;
- The signature on the application is not dated;
- The CMS-855I application was signed by someone other than the individual practitioner applying for enrollment;
- The applicant failed to submit all *of* the forms needed to process a reassignment package within 15 calendar days of receipt (as described *in* section 5.4 of this manual);
- The applicant sent its CMS-855 to the wrong contractor (e.g., the application was sent to Carrier X instead of Carrier Y);
- The applicant completed the form in pencil;
- The applicant submitted the wrong application (e.g., a CMS-855B was submitted to a fiscal intermediary);
- If a Web-generated application is submitted, it does not appear to have been downloaded off of CMS's Web site;
- An old owner or new owner in a CHOW submitted its application more than 3 months prior to the anticipated date of the sale. (This only applies to fiscal intermediaries.)
- The application was faxed or e-mailed in;
- The contractor received the application more than 30 days prior to the effective date listed on the application. (This does not apply to certified providers, *ASCs*, or portable x-ray suppliers.);

- The contractor can confirm that the provider submitted a new enrollment application prior to the expiration of the time period in which the provider is entitled to appeal the denial of its previously submitted application;
- The contractor discovers or determines that the provider submitted a CMS-855 application for the sole purpose of enrolling in Medicaid;
- The CMS-855 is not needed for the transaction in question. (A common example is an enrolled physician who wants to change his reassignment of benefits from one group to another group and submits a CMS 855I and a CMS 855R. As only the CMS 855R is needed, the CMS-855I shall be returned.);
- The CMS-588 was sent in as a stand-alone change of information request (i.e., it was not accompanied by a CMS-855) but was (1) unsigned, (2) undated, or (3) contained a copied, stamped, or faxed signature.

The contractor need not request additional information in any of the scenarios described above. Thus, for instance, if the application was not signed, the contractor can return the application immediately.

***NOTE:** The difference between a “rejected” application and a “returned” application; the former is based on the provider’s failure to respond to the contractor’s request for missing or clarifying information. A “returned” application is considered a non-application.*

For CMS-855A and CMS-855B applications, if the form is signed but it appears the person does not have the authority to do so, the contractor shall process the application normally and follow the instructions in sections 4.15 and 4.16 accordingly. Returning the application on this basis alone is not permitted.

B. Procedures for Returning the Application

If the contractor returns the *application*:

- *It shall* notify the provider via letter or e-mail that the application is being returned, the reason(s) for the return, and how to reapply.
- *It shall* not enter the application into PECOS. No L & T record shall be created.
- Any application resubmission must contain a brand new certification statement page containing a signature and date. The provider cannot simply add its signature to the original certification statement it submitted.
- Return all other documents submitted with the application (e.g., CMS-588, CMS-460).

C. EFT Agreements

A non-signature on the CMS-588 EFT form (assuming that it is submitted in conjunction with a CMS-855 initial application or change request) is not grounds for returning the entire application package. The contractor shall simply develop for the signature using the procedures cited in section 5.3 of this manual. However, the EFT form must contain an original signature when it is finally submitted. Faxed EFT agreements are not permitted. (This is an exception to the general rule in section 5.3 that contractors can receive additional or clarifying information via fax.) Once the provider submits an EFT agreement with an original signature, any additional or clarifying information the contractor needs with respect to that document can be submitted by the provider via fax. (The provider must still, of course, furnish a new signature when it adds the new information.)

4.1 – Basic Information (Section 1 of the CMS-855)

(Rev.)

When processing section 1 of the application, the contractor shall ensure that the provider checks one of the “reason” boxes. It shall also verify, if reported in this section, that the Medicare identification number *and NPI* are correct.

Note that:

- If a provider *seeks* to reestablish itself in the Medicare program after reinstatement from an exclusion, the *transaction shall be treated* as if it were an initial enrollment.
- Hospitals that *request* enrollment with the carrier to bill *for* practitioner services for hospital departments, outpatient locations and/or hospital clinics must submit an initial enrollment application.
- Unless otherwise stated in this manual, the provider may only check one reason for submittal. *Suppose* a supplier is changing its TIN. It must enroll as a new supplier *as well as request* to terminate its existing billing number. The provider must submit two applications: (1) an initial *CMS-855B as a* new supplier, and (2) a CMS-855B change request/voluntary termination. Both transactions cannot be reported on the same application.

Further information on the processing of changes of information, changes of ownership (CHOWs), reactivations, deactivations, etc., can be found in the applicable sections of this manual.

4.2.1 – *Employer* Identification Numbers and Legal Business Names (Rev.)

A. *Employer Identification Numbers*

Sections 1124 and 1124A of the Social Security Act require that Medicare applicants furnish their tax identification number (TIN), as well as the TINs of all entities and persons listed in sections 5 and 6, respectively, of the CMS-855. The TIN can either be an employer identification number (EIN) or a social security number (SSN). *An application cannot be approved until all TINs (whether EINs or SSNs) have been furnished and properly validated.*

The contractor shall validate the applicant's EIN/TIN and legal business name against IRS paperwork, such as a CP-575, a quarterly tax payment coupon, or other IRS correspondence that contains this data. The documentation must be from the IRS. Applications for TINs, such as the SS-4, are not acceptable; provisional TINs are also unacceptable. Moreover, even if the applicant is a sole proprietor, he/she must submit IRS documentation if he/she lists an EIN (as opposed to the SSN) as the TIN. There may be instances where the applicant cannot obtain the required IRS documentation (e.g., the applicant recently changed its name and the IRS has not sent to it an updated document). In such cases, the applicant must furnish an explanation in a separate attachment and provide evidence that links the legal business name with the TIN listed. One option for the applicant is to request a verification letter (IRS 147c) from the IRS that identifies its TIN and legal business name. The applicant may then submit the old IRS document with the old name, a copy of documentation filed with the State and IRS concerning the name change, and an accompanying explanation of the situation. If the applicant fails to provide this information or the data otherwise does not match, the contractor shall deny the application.

If the name on the IRS documentation does not match exactly the name *on* the articles of incorporation, *the contractor shall* use the name on the IRS documentation as the legal business name. If there is a substantial discrepancy between the names on the two documents, the contractor shall contact the provider for clarification.

As for all other EINs listed on the CMS-855 (e.g., owning and managing organizations), the contractor shall use Qualifier.net as the primary review mechanism. The applicant need not submit IRS documentation for these other organizations, unless the contractor specifically requests it.

B. *Qualifier.Net*

The contractor must also check each SSN and EIN listed on the application against Qualifier.net, regardless of whether: (1) the SSN was validated by PECOS, or (2) the provider's EIN was verified by IRS documentation. This is to identify any SSNs or EINs that may have been used previously and to spot instances where, for instance, one person may be using multiple SSNs.

If a number is found in Qualifier.net that differs from the number on the application, the contractor shall reconcile this issue. For example, if the executive summary shows a different name associated with the provider's EIN, the contractor shall investigate further.

The contractor shall deny the application if, after investigation, it determines that:

- The person (e.g., applicant, owner, manager, etc.) has used a different SSN in the past or is currently using multiple SSNs, even if PECOS verified the person's SSN that was listed on the *application*; or
- There is insufficient evidence to link the EIN with the person or entity it is associated with on the form. For instance, suppose an owner lists its EIN in section 5 of the CMS-855. Qualifier.net lists two names next to the EIN, neither of which belongs to the owner. The contractor contacts the applicant for additional information and asks for a copy of IRS documentation verifying the owner's name and associated EIN. The applicant fails to furnish such documentation; as such, the contractor shall deny the application.

(See section 5.2(B) of this manual for more information on the use of Qualifier.net.)

C. Owners and Managers

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

D. Certified Providers

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

4.2.2 – Licenses and Certifications

(Rev.)

The *extent to which* the applicant must complete the licensure or certification information in section 2 of the CMS-855 depends upon the provider type involved. For instance, some States may require a particular provider to be “certified” but not “licensed,” or vice versa.

A. CMS-855B and CMS-855I

The *contractor* shall verify that the supplier is licensed and/or certified to furnish services in:

- The State where the supplier is enrolling;

- Any other State within the *contractor's* jurisdiction in which the supplier (per section 4 of the CMS-855) will maintain a practice location.

Verification can be performed by reviewing the licensure documentation submitted by the applicant. If the *contractor*, in its general review of Qualifier.net, finds inconsistencies between the data on the license and the data in Qualifier.net, the *contractor* shall request clarifying information. (This may occur if the name on the license does not exactly match the name on the application or the name in Qualifier.net. If the *contractor* cannot verify that it is the same person, it shall deny the application.)

The only licenses that must be submitted with the application are those required by Medicare or the State to function as the supplier type in question. Licenses and permits that are not of a medical nature are not required, though business licenses needed for the applicant to operate as a health care facility or practice must be submitted. In addition, there may be instances where the supplier is not required to be licensed at all in a particular State; the *contractor* shall still ensure, however, that the supplier meets all applicable State and Medicare requirements.

The contractor shall also adhere to the following:

- **State Surveys:** Documents that can only be obtained after State surveys or accreditation need not be included as part of the application. (This typically occurs with ambulatory surgical centers (ASCs) and portable x-ray suppliers.) The supplier must, however, furnish those documents that can be submitted prior to the survey/accreditation.

The *contractor* need not verify licenses, certifications, and accreditations submitted by ASCs and portable x-ray suppliers. Instead, the *contractor* shall simply include such documents, if submitted, as part of the enrollment package that is forwarded to the State and/or RO.

Once the *contractor* receives the approval letter or tie-in notice from the RO for the ASC or portable x-ray supplier, the *contractor* is encouraged, but not required, to contact the RO, State agency, or *supplier* for the *applicable* licensing and/or certification data and *to* enter it into PECOS.

- **Notarization:** If the applicant submits a license that is not notarized or "certified true," the *contractor* shall verify the license with the appropriate State agency. (A notarized copy of an original document has a stamp that *says* "official seal," along with the name of the notary public, the State, the county, and the date the notary's commission expires. A certified "true copy" of an original document has a raised seal that identifies the State and county in which it originated or is stored.)
- **Temporary Licenses:** If the supplier submits a temporary license, the *contractor* shall note the expiration date in PECOS. Should the supplier fail to submit the permanent license after the temporary license expiration date, the *contractor* shall

initiate revocation procedures. (A temporary permit – one in which the applicant is not yet fully licensed and must complete a specified number of hours of practice in order to obtain the license – is not acceptable.)

- **Revoked/Suspended Licenses:** If the applicant had a previously revoked or suspended license reinstated, the applicant must submit a copy of the reinstatement notice with the application.
- **Date of Enrollment** – For suppliers other than ASCs and portable x-rays, the date of enrollment is the date the *contractor* approved the application. The enrollment date cannot be made retroactive. To illustrate, suppose the supplier met all the requirements needed to enroll in Medicare (other than the submission of a CMS-855I) on January 1. He sends his CMS-855I to the contractor on May 1, and the contractor approves the application on June 1. The date of enrollment is June 1, not January 1. (Note that *the matter* of the date of enrollment is separate from the question of *the date from which* the supplier may bill.)

B. CMS-855A

Documents that can only be obtained after State surveys or accreditation need not be included as part of the application, nor *must* the data be *provided* in section 2 of the CMS-855A. The *provider* must, however, furnish those documents that can be submitted prior to the survey/accreditation.

The *contractor* need not verify licenses, certifications, and accreditations that were submitted. It shall simply include such documents as part of the enrollment package that is forwarded to the State and/or RO.

Once the contractor receives the approval letter or tie-in notice from the RO, the contractor is encouraged, but not required, to contact the RO, State agency, or provider for the *applicable* licensing and/certification data and *to* enter it into PECOS.

4.2.3 – Correspondence Address

(Rev.)

A. General

The correspondence address must be *one* where the contractor can directly contact the applicant to resolve any issues *once the provider is enrolled in the Medicare program*. It cannot be the address of a billing agency, management services organization, *chain home office*, or the provider's representative (e.g., attorney, financial advisor). It can, however, be a P.O. Box or, in the case of *an individual practitioner*, the person's home address.

The contractor shall call the telephone number listed in this section to verify that the contractor can directly contact the applicant. If an answering service appears and the contractor can identify it as the applicant's personal service, it is not necessary to talk

directly to the applicant or an official thereof. *The contractor* only needs to verify that the applicant can be reached at this number.

B. Contact Person

The contractor should use the contact person listed in section 13 of the CMS-855 for all communications specifically related to the provider’s submission of a CMS-855 initial enrollment, change of information request, etc. All other provider enrollment-oriented matters shall be directed to the correspondence address. For instance, assume a provider submits an initial CMS-855 on March 1. The application is approved on April 15. All communications specifically related to the CMS-855 submission between March 1 and April 15 should be sent to the contact person (or, if section 13 is blank, to an authorized/delegated official or the individual practitioner). After April 15, all provider enrollment-oriented correspondence shall go to the correspondence address. Now assume that the provider submits a change of information request on August 1, which the contractor approves on August 30. All communications specifically related to the change request should go to the designated contact person between August 1 and August 30.

Notwithstanding the above, all approval/denial letters should be sent to the contact person. However, the contractor retains the discretion to send the letter to another address listed on the CMS-855 if dictated by circumstances.

In short:

- CMS strongly recommends that all communications (e.g., requests for additional information) specifically related to the submission of a CMS-855 (or CMS-588) application be addressed to the contact person in Section 13. However, the contractor retains the discretion to use the correspondence address if circumstances so warrant.*
- All provider enrollment-oriented communications/correspondence not specifically related to a CMS-855 (or CMS-588) transaction shall be sent to the correspondence address. The contractor has the discretion to determine whether a particular communication is “specifically related” to a CMS-855 submission or whether a particular communication is “provider enrollment-oriented.”*
- For purposes of this section 4.2.3(B), the term “approved” includes “recommended for approval.”*

4.2.4 – Accreditation ***(Rev.)***

If the provider checks “Yes,” the contractor shall ensure that the listed accrediting body is one that CMS recognizes in lieu of a State survey or other certification for the provider type in question. If the accrediting body is not recognized by CMS, the contractor shall advise the provider accordingly. (Note, however, that the provider may not intend to use

the *listed* accreditation in lieu of the State survey and merely *furnished* the accrediting body in response to the question.)

4.2.5 – Section 2 of the CMS-855A

(Rev.)

A. Cost Reporting Data

If a provider is already enrolled and: (1) wants to change its cost report date, and (2) is not undergoing a CHOW, it must notify CMS of this no less than 120 days prior to the close of the reporting period which the change proposes to establish. (See Pub. 15-1, Part 1, section 2414.3.)

If the *contractor* chooses to permit *such* notification to be made via the CMS-855A, *it* shall advise the provider upon enrollment that the change must be reported in accordance with the 120-day limit, not the 90-day requirement listed on the CMS-855A. The *contractor* shall document that such notice was given.

B. Home Health Agency (HHA) Branches, Hospital Units, and Outpatient Physical Therapy/Occupational Therapy (OPT/OT) Extension Sites

As explained in section 12.1.6, 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 *such* that it shares administration, supervision, and services with the *parent*. If an existing HHA wishes to add a branch, it is considered a change of information on the CMS-855A. *An HHA subunit, meanwhile*, is a semi-autonomous organization under the same governing body as *the* parent HHA *and* serves patients in a geographic area different from that of the *parent*. *Because of its distance from the subunit, the parent is incapable of sharing administration, supervision and services with the subunit on a daily basis*. If the HHA wants to add an HHA subunit, it must complete an initial enrollment application for the subunit. (The subunit also signs a separate provider agreement.)

If an enrolled hospital seeks to add a rehabilitation, psychiatric, or swing-bed unit, it should submit a change of information and not an initial enrollment application. If an *OPT/OT* provider wishes to add an extension site, a CMS-855 change request should be submitted.

When the provider seeks to add an HHA branch or a hospital unit, the *contractor* shall make a recommendation for approval or denial and forward the package to the State *as described in section 7.2 of this manual*. However, the *contractor* shall emphasize to the provider that a recommendation of approval of the addition of the branch or unit does not signify CMS's approval of the new location. Only the RO can approve the addition.

With respect to PECOS, the *contractor* shall create a separate enrollment record for the hospital unit. However, a separate enrollment record for each HHA branch *and OPT/OT extension site* is not required. These locations can simply be listed on the main provider's enrollment record.

C. Critical Access Hospitals

Critical access hospitals (CAHs) are not considered to be a hospital sub-type for enrollment purposes. Thus, if *an existing* hospital wishes to convert to a CAH, it must complete a whole new CMS-855A as an initial enrollment.

D. Transplant Centers

For purposes of Medicare enrollment, a hospital transplant center is treated similarly to a hospital sub-unit. If the hospital wishes to add a transplant center, it must check the "other" box in section 2A2 of the CMS-855A, write "transplant center" on the space provided, and follow the standard instructions for adding a sub-unit. The contractor shall process the application in the same manner it would the addition of a hospital sub-unit; however, no separate enrollment in PECOS need be created for the transplant center.

4.2.6 – Section 2 of the CMS-855B

(Rev.)

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

- If the group indicates that it renders services in patients' homes, the contractor shall verify that the group has an established private practice where it can be contacted directly and where it maintains patients' records.
- If the group answers "yes" to question 2, 3, 4, or 5, it must submit a copy of the lease agreement *giving* the group exclusive use of the facilities for PT/OT services. If no such lease exists, the *contractor* shall deny the application.

4.2.7 – Section 2 of the CMS-855I

(Rev.)

A. Specialties

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

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

B. Education *for Non-Physician Practitioners*

The *contractor* shall verify all required educational information for non-physician practitioners. The non-physician practitioner must meet all Federal and State requirements and must provide documentation of courses or degrees taken to satisfy Medicare requirements. If the applicant does not meet the educational requirements, the *contractor* shall deny the application.

Physicians are not required to submit a copy of their degree with their application unless requested to do so by the contractor. *If need be, the contractor* can verify this information via a State licensure/certification Web site or other mechanism.

C. Resident/Intern Status

If the applicant is a *"resident" in* an "approved medical residency program" (*as these two terms are defined at 42 CFR § 413.75(b)*), the contractor shall refer to Pub. 100-02, chapter 15, section 30.3 for further instructions. (The contractor may also want to refer to 42 CFR §415.200, which states that services furnished by residents in approved programs are not "physician services.")

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

D. Physician Assistants

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

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

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

E. Psychologists Billing Independently

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

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

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

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

If the OT/PT answers “yes” to question 2, 3, 4, or 5, he/she must submit a copy of the lease agreement that gives him/her exclusive use of the facilities for *OT/PT* services. If no such lease exists, the *contractor* shall deny the application.

4.3 – Adverse Legal Actions/Convictions

(Rev.)

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

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

If the applicant indicates that a felony or misdemeanor conviction has been imposed against a person or entity listed on the CMS-855, the contractor shall refer the matter to its DPSE contractor liaison for further instructions. (CMS may refer the matter to the

OIG or PSC, if necessary.) In *its referral* to CMS, the contractor shall furnish a brief explanation of the matter along with the applicable section of the CMS-855 (e.g., section 3, section 5). The contractor shall neither approve nor deny the application until *DPSE* issues a final *directive to* the contractor.

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

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

If the applicant states in section 3, 4A of the CMS-855I, 5, and/or 6 that the person or entity in question has never had an adverse legal action imposed against him/her/it but the contractor's review of Qualifier.Net indicates otherwise, the contractor shall contact *DPSE* for further instructions. The contractor shall neither approve nor deny the application until *DPSE* issues a final directive, which could include an instruction to deny the application based on false information furnished by the applicant. (See section 6.2 of this manual *for further details on the handling of potentially falsified applications.*)

In any situation where CMS directs the contractor to deny an application based on an adverse legal action, the contractor shall notify – *via fax or e-mail* - all other contractors that have enrolled the applicant. Payment stoppages and recoupment actions may be warranted.

Chain Home Offices, Billing Agencies, and HHA Nursing Registries

If a Qualifier.net search of the entities listed in sections 7, 8, or 12 of the CMS 855 indicate adverse legal history, the contractor shall handle the matter in accordance with the *instructions in* this section 4.3.

4.4 – Practice Location Information *(Rev.)*

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

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

A. Practice Location Verification

The contractor shall verify via Qualifier.net that the practice locations listed on the application actually exist; *note that the practice location name may be the "doing business as" name*. If a *particular location* is not shown on the executive summary, the contractor shall request clarifying information. (For instance, the contractor can request that the applicant furnish letterhead showing the appropriate address.)

The contractor shall also verify that the reported telephone number is operational and connects to the practice location/business listed on the application. (The telephone number must be *one* where patients and/or customers can reach the applicant to ask questions or register complaints.) The contractor shall match the applicant's telephone number with known, in-service telephone numbers, using Qualifier.net to correlate telephone numbers with addresses. If the applicant uses his/her/its cell phone for their business, the contractor shall verify that this is a telephone connected directly to the business. If the contractor cannot verify the telephone number, it shall request clarifying information from the applicant; the inability to confirm a telephone number may indicate that an onsite visit is necessary. In some *instances, a* 1-800 number or out-of-state number may be acceptable if the applicant's business location is in another State but his/her/its practice locations are within the contractor's jurisdiction.

With respect to individual and organizational suppliers other than ASCs, portable x-ray suppliers, *and IDTFs*, the *contractor* shall use the date in section 4A of the CMS-855B or section 4C of the CMS-855I as the date from which the applicant can bill the Medicare program. (This assumes, of course, that the supplier *met all of the necessary requirements as of that date*.) In situations where the date listed appears to be beyond a reasonable amount of time (e.g., older than 12 months), the *contractor* shall *request clarifying information from the applicant*.

In addition:

- If an individual practitioner or group practice: (1) is adding a practice location and (2) is normally required to complete a questionnaire in section 2 of the CMS-855I or CMS-855B specific to its supplier type (e.g., psychologists, physical therapists), the person or entity must submit an updated questionnaire to incorporate services rendered at the new location.
- All applicants submitting a CMS-855A must submit the 9-digit zip code for each practice location listed. Persons and entities submitting the CMS-855B or CMS-855I are strongly encouraged, but not required, to disclose the 9-digit zip code for each location.

B. Do Not Forward (DNF)

The contractor shall follow the DNF initiative *instructions in* Pub. 100-04, chapter 1, section 80.5. *Remittance* advices and checks shall be flagged if returned from the post office, as *this* indicates that *the provider's "special payment" address* (section 4 of the CMS-855) has *changed. (Returned mail other remittance advices or checks are not considered to be DNF mail.)* The provider *should submit* a CMS-855 request to change this address; *if the provider is not in PECOS, it must complete an entire CMS-855 application.*

In situations where a provider is closing his/her/its business and has a termination date (e.g., he/she is retiring), the contractor will *likely* need to make payments for prior services rendered. Since the practice location has been terminated, the contractor may encounter a DNF message. If so, the contractor should request the *provider* to complete the "special payment" address section of the CMS-855 and to sign the certification statement. The contractor, however, shall not collect any other information unless there is a need to do so.

C. Remittance Notices/Special Payments

For new enrollees, all payments must be made via *EFT*. The contractor shall thus ensure that the provider has *completed and signed* the CMS-588, and shall verify that the bank account is in compliance with Pub. 100-04, chapter 1, section 30.2.

If an enrolled provider that currently receives paper checks submits a CMS-855 change request – no matter what the change involves – the provider must also submit:

- A CMS-588 that switches its payment mechanism to EFT. (The change request cannot be processed until the CMS-588 is submitted.) All future payments (excluding special payments) must be made via EFT.
- An updated section 4 that identifies the provider's desired "special payments" address.

The contractor shall *also* verify that the bank account is in compliance with Pub. 100-04, chapter 1, section 30.2.

(Once a provider changes its method of payment from paper checks to EFT, it must continue using EFT. A provider cannot switch from EFT to paper checks.)

The "special payment" address may only be one of the following:

- One of the provider's practice locations
- A P.O. Box

- The provider's billing agent. The contractor shall request additional information if it has any reason to suspect that the arrangement – at least with respect to any special payments that *might* be made – *may violate* the Payment to Agent rules in Pub. 100-04, chapter 1, section 30.2.
- The chain home office address. Per Pub. 100-04, chapter 1, section 30.2, a chain organization may have payments to its providers sent to the chain home office. *The legal business name and TIN of the chain home office must be listed on the CMS-588.*
- *Correspondence address*

4.4.1 – Section 4 of the CMS-855A *(Rev.)*

Hospitals and other providers must list all addresses where they (and not a separately enrolled provider/supplier type, such as a nursing home) furnish services. The provider's primary practice location should be the first location *identified* in section 4 and the *contractor* shall treat it as such for purposes of PECOS entry, unless there is evidence to the contrary. Note that hospital departments located at the same address as the *main facility* need not be listed as practice locations on the CMS-855A.

If a practice location (*e.g., hospital unit*) has a *CCN* that is in any way different from that of the main provider, the *contractor* shall create a separate enrollment record in PECOS for that location; *this does not apply, however, to HHA branches, OPT/OT extension sites and transplant centers.*

HHAs should complete section 4A with their administrative address.

If the provider's address and/or telephone number cannot be verified via Qualifier.net, the contractor shall request clarifying information from the provider. If the provider states that the facility and its phone number *are not yet operational*, the contractor may continue processing the application. However, *it* shall note in its recommendation letter that the address and telephone number of the facility *could not be verified*. For purposes of PECOS entry, the contractor can temporarily use the date the certification statement was signed as the effective date.

4.4.2 – Section 4 of the CMS-855B *(Rev.)*

A. Ambulatory Surgical Centers (ASCs) and Portable X-ray Suppliers

If the applicant's address or telephone number cannot be verified via Qualifier.net, the contractor shall contact the applicant for further information. If the supplier states that

the facility or its phone number is not yet operational, the contractor shall continue processing the application. *However, it shall note in its recommendation letter that the address and telephone number of the facility could not be verified*

For purposes of PECOS entry, the contractor can temporarily use the date the certification statement was signed as the effective date.

B. Reassignment of Benefits

Per Pub. 100-04, chapter 1, section 30.2.7, a *contractor* may permit a reassignment of benefits to any *eligible* entity regardless of where the service was rendered or whether the entity owned or leased that location. As such, the *contractor* need not verify the entity's ownership or leasing arrangement with respect to the reassignment.

4.4.3 – Section 4 of the CMS-855I (Rev.)

A. Solely-Owned Organizations

The former practice of having solely-owned practitioner organizations (as explained and defined in section 4A of the CMS-855I) complete a CMS-855B, a CMS-855R, and a CMS-855I has been discontinued. All pertinent data for these organizations can be furnished via the CMS-855I alone. The *contractor*, however, shall require the supplier to submit a CMS-855B, CMS-855I and CMS-855R if, during the verification process, it discovers that the supplier is not a solely-owned organization. *Note that a solely-owned supplier type that normally completes the CMS-855B to enroll in Medicare must still do so. For example, a solely-owned LLC that is an ambulance company must complete the CMS-855B, even though section 4A makes mention of solely-owned LLCs. Use of section 4A of CMS-855I is limited to suppliers that perform physician or practitioner services.*

Sole proprietorships need not complete section 4A of the CMS-855I. By definition, a sole proprietorship is not a corporation, professional association, etc. Do not confuse a sole proprietor with a physician whose business is that of a corporation, LLC, etc., of which he/she is the sole owner.

In section 4A, the supplier may list a type of business organization other than a professional corporation, a professional association, or a limited liability company (e.g., closely-held corporation). This is acceptable so long as that business type is recognized by the State in which the supplier is located.

The *contractor* shall verify all data furnished in section 4A (e.g., legal business name, *TIN*, adverse legal actions). If section 4A is left blank, the *contractor* may assume that it does not pertain to the applicant.

A solely-owned physician or practitioner organization that utilizes section 4A to enroll in Medicare can generally submit change of information requests to Medicare via the CMS-855I. However, if the change involves data not captured on the CMS-855I, the change must be made on the applicable CMS form (i.e., CMS-855B, CMS-855R).

B. Individual Affiliations

If the applicant indicates that he/she intends to render all or part of his/her services in a group setting, the *contractor* shall ensure that the applicant (or the group) has submitted a CMS-855R for each group to which the individual plans to reassign benefits. The *contractor* shall also verify that the group is enrolled *in Medicare*. If it is not, the *contractor* shall enroll the group prior to approving the reassignment.

C. Practice Location Information

A practitioner who only renders services in patients' homes (i.e., house calls) must supply his/her home address in section 4C. In addition, if a practitioner renders services in a retirement or assisted living community, section 4C must include the name and address of that community. In either case, the contractor shall verify that the address is a physical address. Post office boxes and drop boxes are not acceptable.

D. Sole Proprietor Use of EIN

The practitioner must obtain a separate EIN if he/she wants to receive reassigned benefits as a sole proprietor.

E. NPI Information for Groups

If a supplier group/organization is already established in PECOS (i.e., status of "approved"), then the physician or non-physician practitioner is not required to submit the NPI in 4B2 of the 855I. In short, if group/organization is already established in PECOS, the group/organization does not need to include an NPI in section 4B2. The only NPI that the physician or non-physician practitioner must supply is the NPI found in section 4C.

NOTE: Physicians and non-physician practitioners are required to supply the NPI in *section* 4B2 of the *CMS-855I* for groups/organizations not established in PECOS with a status of "approved."

4.13 – Contact Person

(Rev.)

The contractor should use the contact person listed in section 13 of the CMS-855 for all communications specifically related to the provider’s submission of a CMS-855 initial enrollment, change of information request, etc. All other provider enrollment-oriented matters shall be directed to the correspondence address. For instance, assume a provider submits an initial CMS-855 on March 1. The application is approved on April 15. All communications specifically related to the CMS-855 submission between March 1 and April 15 should be sent to the contact person (or, if section 13 is blank, to an authorized/delegated official or the individual physician/practitioner). After April 15, all provider enrollment-oriented correspondence shall go to the correspondence address. Now assume that the provider submits a change of information request on August 1, which the contractor approves on August 30. All communications specifically related to the change request should go to the designated contact person between August 1 and August 30.

Notwithstanding the above, all approval/denial letters should be sent to the contact person. However, the contractor retains the discretion to send the letter to another address listed on the CMS-855 if dictated by circumstances.

In short:

- CMS strongly recommends that all communications (e.g., requests for additional information) specifically related to the submission of a CMS-855 (or CMS-588) application be addressed to the contact person in Section 13. However, the contractor retains the discretion to use the correspondence address if circumstances so warrant.*
- All provider enrollment-oriented communications/correspondence not specifically related to a CMS-855 (or CMS-588) transaction shall be sent to the correspondence address. The contractor has the discretion to determine whether a particular communication is “specifically related” to a CMS-855 submission or whether a particular communication is “provider enrollment-oriented.”*
- For purposes of this section 4.13, the term “approved” includes “recommended for approval.”*

If the contractor discovers that the contact person qualifies as an owning or managing individual, the provider shall list the person in section 6 of the application.

12.1.6 - Home Health Agencies (HHAs)

(Rev.)

A. General Background Information

An HHA is an entity that provides skilled nursing services and at least one of the following therapeutic services: speech therapy, physical therapy, occupational therapy, home health aide services, and medical social services. The services must be furnished in a place of residence used as the patient's home.

Like most certified providers, HHAs receive a State survey or survey from an approved accrediting organization to determine compliance with Federal, State, and local laws, and must also sign a provider agreement. All HHA services, moreover, must be part of a plan of care established by a physician, accompanied by a certification from the doctor that the patient needs home health services. HHA services can be covered even if the patient lives with someone who might ordinarily be able to perform such services himself/herself.

B. Capitalization Requirements

To ensure that each HHA has sufficient operating funds, 42 CFR §489.28 requires that each HHA furnish written documentation verifying that it has sufficient operating funds for the first 3 months of its Medicare operations. This is informally known as the "capitalization requirement" and is addressed in Section 12 of the Form CMS-855A. The question of what constitutes "sufficient" funds is usually left to the intermediary's discretion. Factors that the intermediary considers in its determination include: the number of home visits the HHA plans to make in its first 3 months and first 12 months of operation; the geographic area involved; and the capitalization figures for comparable HHAs in the same jurisdiction. To illustrate, suppose HHA #1 will be performing hundreds of visits in its first 90 days, while HHA #2 will be doing just a few dozen. Higher capitalization may be required of HHA #1 than HHA #2 since far more Medicare funds will be going to #1, thus increasing the risk to Medicare if #1 ceases operations.

In addition:

- The documentation of funds typically must include some sort of financial statement accompanied by an attestation from the bank certifying the availability of funds.
- A certain percentage of the available funds cannot have been borrowed.
- *Per 42 CFR § 489.28(a), the new owner in an HHA CHOW, acquisition/merger, or consolidation must meet the capitalization requirements if the ownership change results in the issuance of a new provider number (e.g., the new owner will not assume the provider agreement and is therefore enrolling as a new provider).*

(For more information on HHA capitalization requirements, see section 4.12 of this manual.)

C. HHA Components

There are three potential “components” of an HHA organization:

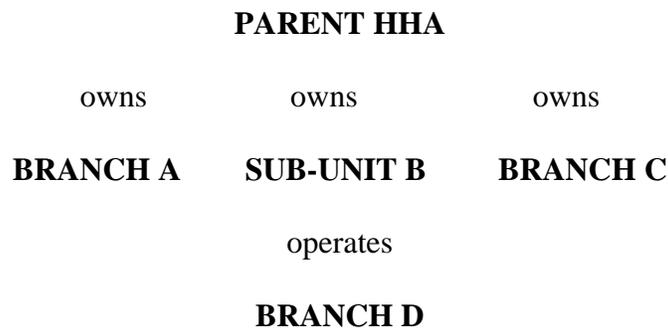
Parent – The parent HHA is the entity that maintains overall administrative control of its location(s).

Sub-unit – A sub-unit is associated with the parent HHA, but services a different geographic area. It is thus considered a semi-autonomous HHA since it is too far away from the parent HHA to share administration/supervision on a day-to-day basis. This means that HHA sub-units must separately enroll in Medicare, obtain a separate State survey, and sign a separate provider agreement. As with parent HHAs, sub-units receive their own 6-digit **CCN**.

Branch – Is a location or site that services patients in the same geographic area as the parent and shares administration with the parent on a daily basis. Consequently, unlike sub-units, branches need not enroll separately. They can be listed as practice locations on the main provider’s (or sub-unit’s) Form CMS-855A. Though the branch receives a 10-digit CCN identifier, it bills under the parent HHA’s or sub-unit’s **CCN** number.

The question of whether a particular location qualifies as a branch or a sub-unit – and hence requires a separate Form CMS-855A enrollment – is resolved by the RO.

Consider the following scenario:



Here, the parent HHA has two branches (A and C) and one sub-unit (B). B also has a branch (D). They will be enrolled as follows:

- The parent HHA must complete a Form CMS-855A, undergo a State survey, and sign a provider agreement;

- Branches A and C would be listed as practice locations on the parent’s Form CMS-855A because a branch is sufficiently “attached” to the parent to be considered part of it;

- Sub-unit B would enroll separately from the parent and would complete its own Form CMS-855A, undergo its own survey, and sign its own agreement. For purposes of enrollment, it is considered an entity separate and distinct from the parent, henceforth requiring a separate enrollment. (This also means that Sub-unit B would not have to be listed on the parent’s Form CMS 855A as a practice location.)

- Because sub-units can have branches just like parents can, Branch D would be listed as a practice location on Sub-unit B’s application.

- See Pub. 100-07, Chapter 2, section 2182 for discussion of branches.

D. Out-of-State HHA Branches

In general, an HHA can only have a branch in another State (and treat it as a branch, rather than a separate HHA) if there is a reciprocity agreement between the two States. If none exists, the out-of-state location must enroll as a new provider by submitting a new Form CMS-855A and signing a separate provider agreement. It cannot be treated as a branch/practice location of the main HHA. (See Pub. 100-07, chapter 2, section 2184 for specific provisions regarding HHAs that cross State lines.)

E. Additional Data

For more information on HHAs, refer to:

- Sections 1861(o) and 1891 of the Social Security Act;
- 42 CFR Part 4841
- 42 CFR § 489.28 (capitalization);
- Pub. 100-07, chapter 2, sections 2180 – 2198C (State Operations Manual);
- Pub. 100-04, chapter 10 (Claims Processing Manual); and
- Pub. 100-02, chapter 7 (Benefit Policy Manual)

18.2 - Provider Enrollment Inquiries

(Rev.)

The contractor's customer service unit may handle provider enrollment inquiries that do not involve complex enrollment issues. Examples of inquiries that can be processed by customer service units include:

- Application status checks (e.g., "Has the contractor finished processing my application?");
- Furnishing information on where to access the CMS-855 forms (and other general enrollment information) on-line;
- Explaining to providers/suppliers which CMS-855 forms should be completed.
- Contractors may wish to consider establishing electronic mechanisms by which providers can obtain updates on the status of their enrollment applications via the contractor's Web site or via automated voice response (AVR).

Contractors are strongly encouraged to establish e-mail "listserves" with the provider community to disseminate important information thereto, such as contractor address changes, new CMS enrollment policies or internal contractor procedures, reminders about existing policies, etc. By being proactive in distributing information to their providers on a regular basis (e.g., weekly, bi-weekly), contractors can reduce the number of policy inquiries they receive and help facilitate the submission of complete and accurate CMS-855 applications.