CMS Manual System

Pub 100-08 Medicare Program Integrity

Transmittal 134

Department of Health & Human Services (DHHS)

Center for Medicare & Medicaid Services (CMS)

Date: DECEMBER 30, 2005

Change Request 4213

SUBJECT: Change in Provider Enrollment Timeliness Standards

I. SUMMARY OF CHANGES: The Division of Provider and Supplier Enrollment is modifying the instructions involving several activities contractors are currently required to perform under Pub. 100-08, chapter 10. First, the timeframes in which contractors must process CMS 855 enrollment applications are modified as identified in this change request. Second, Medicare carriers shall count incoming CMS 855B, CMS 855I and CMS 855R applications in accordance with the instructions outlined in this change request. The purpose of this change request is to create administrative and financial flexibility in the event that contractors are assigned additional tasks in the future. Moreover, clarification of the timeliness and counting requirements will facilitate a simpler and more consistent enrollment process.

NEW/REVISED MATERIAL
EFFECTIVE DATE: March 01, 2006
IMPLEMENTATION DATE: March 01, 2006

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R = REVISED, N = NEW, D = DELETED

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	10/Table of Contents
R	10/13/Changes of Information
R	10/15/Timeframes for Processing Enrollment Applications

III. FUNDING:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2006 operating budgets.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Unless otherwise specified, the effective date is the date of service.

Attachment - Business Requirements

Pub. 100-08	Transmittal: 134	Date: December 30, 2005	Change Request 4213

SUBJECT: Change in Provider Enrollment Timeliness Standards

I. GENERAL INFORMATION

A. Background: The Division of Provider and Supplier Enrollment is modifying the instructions involving several activities contractors are currently required to perform under Pub. 100-08, chapter 10. First, the timeframes in which contractors must process CMS 855 enrollment applications are modified as identified in this change request. Second, Medicare carriers shall categorize incoming CMS-855B, CMS-855I, and CMS-855R applications in accordance with the instructions outlined in this change request.

B. Policy: The purpose of this change request is to create administrative and financial flexibility in the event that contractors are assigned additional tasks in the future. Moreover, clarification of the timeliness and counting requirements will facilitate a simpler and more consistent enrollment process.

All applications received on or after the effective date of this change request are subject to the timeliness standards outlined herein. Applications that are pending as of the effective date of this change request are not subject to the timeliness standards identified herein.

II. BUSINESS REQUIREMENTS

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4213.1	Medicare contractors shall process eighty percent of initial CMS-855A, CMS-855B, and CMS-855I applications within 60 calendar days of receipt. Ninety percent of these applications shall be processed within 120 calendar days of receipt. Ninety-nine percent of these applications shall be processed within 180 calendar days of receipt.	X	X	X						National Supplier Clearing house
4213.2	Medicare contractors shall process eighty percent of CMS-855A, CMS-855B, and CMS-855I change of information applications within 45 calendar days of receipt. Ninety percent of these applications shall be processed within 60	X	X	X						National Supplier Clearing house

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	calendar days of receipt. Ninety-nine percent of these applications shall be processed within 90 calendar days of receipt.									
4213.3	Medicare carriers shall count and categorize the number of CMS-855B, CMS-855I, and CMS-855R applications they process in accordance with the instructions outlined in this change request.			X						

III. PROVIDER EDUCATION: None

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: March 1, 2006 **Implementation Date:** March 1, 2006 **Pre-Implementation Contact(s):** Frank Whelan (410) 786-1302 **Post-Implementation Contact(s):** Frank Whelan (410) 786-1302	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.**

***Unless otherwise specified, the effective date is the date of service.**

Medicare Program Integrity Manual
Chapter 10 - Healthcare Provider/Supplier Enrollment

Table of Contents
(Rev. 134, 12-30-05)

13 - Changes of Information

(Rev. 134, Issued: 12-30-05; Effective/Implementation Dates: 03-01-06)

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 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 *or 16* 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 for a change to a pay-to-address. The initial application's certification statement is a verification tool and must be checked with any change request for a change to a pay-to-address. If the contractor has any reason to question the validity of the certification statement, alert your PSC for *advice.*

"Pay to" address or EFT changes

If the provider has never completed a CMS-855 before and is now submitting any change to its "pay to" address or EFT information, the provider must complete an entire CMS-855 application. An exception to this rule is if the contractor has on file a previous CMS-855 change of information request from the provider that is signed by the same authorized or delegated official that has signed the "pay to" or EFT change request. In this situation, the provider need not submit an entire application. However, the contractor must compare the two signatures.

If the provider has a completed CMS-855 on file, the rules in the previous paragraph are inapplicable; no full CMS-855 is needed.

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. *The only exception to this involves situations where the provider's phone number or address is changing due to circumstances not caused by the provider. Common examples would be a change in the provider's area code or zip code, or if the locality changes the provider's street name. In these cases, the provider must – if requested to by the contractor - submit a copy of county/state documentation verifying the change.*

When the provider submits a change of information request and already has a CMS-855 on file, the provider must:

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. *Sign Section 15 and/or 16 of the form. If the signer has never been reported in Section 6 of the form, Section 6 must be completed in full with information about the individual. The contractor shall check the individual against Qualifier.net and make a record in the enrollment file that this was performed.*

We understand that it is not possible to compare signatures *if* the enrolled provider/supplier does not have an application on file. *In such situations,* 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.

If contacted by a group *that* 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. *For certified providers, the instructions in Section 12 of this manual should be followed.)*

Any change to a *p*ay-to-*a*ddress requires the contractor to verify/validate this request. See *the applicable* "*pay-to-address" section* for further instructions.

Note that any changed information submitted by an applicant prior to the date the contractor finishes processing the application is considered an update to the original application. It is not considered to be a separate change of information. For instance, suppose the provider submitted an initial enrollment application to the fiscal intermediary. On the 58th day – one day before the intermediary planned to make its recommendation for approval – the provider submitted updates to its Section 6 data. The intermediary must process this information prior to making its recommendation, even if it takes it beyond the 60-day limit. It cannot make its recommendation as planned on the 59th day and simply process the Section 6 data as a change of information after the fact. Of course, if the late-arriving data takes the timeframe over 60 days, the contractor should document the file and explain the special circumstances involved.

This policy also applies to changes of information – that is, additional information submitted by an enrolled provider prior to the date the contractor finishes processing the provider's initial change of information. Thus, suppose a provider submits a change of information. On the 44th day, it submits more information that it wants changed. Because the contractor has not finished processing the first change request, it should – for processing purposes – treat the data in the second change request as being part of the first one.

Processing the Change of Information

The contractor must process *80* percent of *these* applications within *45 calendar* days *of receipt*. *Ninety* percent of *these* applications must be processed within *60 calendar* days *of receipt*, *and 99 percent of these applications must be processed within 90 calendar days of receipt.* 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
- *Updating the requested change in both PECOS and the UPIN registry. If the provider submits a full application, all data on the CMS-855 (including the changed data) must be entered into PECOS.*

This 45-day cycle applies to situations where the provider/supplier has never completed a CMS-855 before and now wants to make a change to its EFT/pay to address information. The contractor should not begin processing the change request until the full, completed form comes in; the 45-day processing time clock does not start until the completed form arrives. However, it is strongly recommended that the contractor begin facilitating the EFT/pay to change request immediately upon receipt of the full application so that there is no interruption in payment.

For: (1) fiscal intermediaries, and (2) carriers processing ASC or portable x-ray applications, the processing cycle ends on the date a recommendation for approval or denial of the change is made. If the change is minor and does not require a recommendation (e.g., it need not be forwarded to and approved by the State or Regional Office (RO)), the cycle ends on the date the contractor finally approved the change.

Any time a request for change is received, provide written (or via *e*-mail) 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 *42 CFR 413.65."*

Special Situations Involving Certified Providers

- *On occasion, a provider may submit a change of information request (COI) after the intermediary makes its recommendation but before a tie-in notice is issued. In these cases, the intermediary must still process the COI in accordance with existing instructions. However, it need not enter the COI into PECOS until the tie-in notice is issued (assuming one would normally be issued for this type of COI). In addition, <u>any</u> changed or corrected information submitted after the intermediary makes its recommendation but before a tie-in is issued should be processed as a COI. The intermediary should not simply take the changed information/corrected pages and, immediately upon receipt, send them directly to the State/RO to be incorporated into the existing application. The intermediary must process the submission as a COI.*

- *An increasing number of hospitals are converting to critical access hospitals (CAHs). Sometimes, the intermediary will receive a tie-in notice authorizing the conversion; however, the provider never completed a CMS-8555A change of information request. (In other words, the provider went directly to the State/RO and bypassed the intermediary and the CMS-855 process.) In such a situation, the intermediary shall have the provider complete a CMS-855A change of information.*

  This principle also applies to other changes of information, such as the addition of a Home Health Agency (HHA) branch or hospital sub-unit. If the intermediary receives a tie-in notice and no 855A change of information was completed, the intermediary shall have the provider submit one.

- *A few COI requests require a recommendation for approval/denial, referral to the State/RO and/or a tie-in/tie-out notice. Some changes are so minor that there is no real need to refer the matter to the State or RO.*

  The following is a list of transactions that should be accompanied by a recommendation and referral to the State/RO (unless the RO specifies otherwise). Note that this list is not necessarily exhaustive:

  - *The addition/subtraction of a practice location, regardless of whether a tie-in or tie-out notice would normally be issued. This would include any change in the address of an existing practice location as well as the addition of an HHA branch or hospital or psych/rehab unit.*
  - *Change in hospital type (e.g., from a general hospital to a CAH; from long-term to acute care).*
  - *Large-scale stock transfers. These situations usually do not qualify as CHOWs, but the State/RO might want to be advised of the situation.*
  - *Change in the legal business name or tax identification number that does not involve a CHOW.*
  - *Changes in adverse legal history, such as a recent criminal conviction.*

  Most other transactions do not require a recommendation and referral to the State/RO. The intermediary can simply send a letter to the provider notifying the latter that the change has been made. The intermediary need not send a copy of the letter to the State or RO. However, because each RO may have different policies as to those COIs that it wishes to review and/or issue tie-in/tie-out notices, it is strongly advised that you contact your RO to specifically identify those COI transactions that should be referred to the RO, as well as to find out whether the RO will issue a formal approval notice to the provider/FI. This will also dictate when the PECOS status can be flipped to "approved." Thus, if you have confirmed that a particular COI does not require notification of the State/RO or does not otherwise need State/RO approval, the intermediary can "flip" the PECOS status to "approved" once the change has been processed. For cases where a tie-in or RO approval is required, the intermediary should process the change but not switch the record's status to "approved" until such approval has been received from the RO.

  If you refer a matter to the State/RO and have not received a tie-in or other notice signifying that the change has been approved, you may contact the RO to see if approval is forthcoming.

  Note that in situations where the provider has no CMS-855 on file and submits a full one as part of a change of information (e.g., change of "pay to" address), it is not automatically necessary to send the application to the State and RO. Whether or not a recommendation for approval and referral to the State/RO is required depends on what the underlying change involves. For instance, if the provider was only submitting a change of EFT/"pay to" address, this can be approved by the FI without a referral. If the provider was adding an HHA branch, however, and the provider agrees to submit an entire CMS-855 in the process, the FI should make a recommendation and refer it to the State. (The FI should forward the whole application to the State with a note stating that the only matter the State needs to consider is the branch addition.)

- *In situations where the audit intermediary differs from the claims intermediary – as might happen with a provider-based HHA, where the parent provider's intermediary is the audit intermediary and the RHHI is the claims intermediary – the audit intermediary is responsible for processing all changes of information. This includes all "pay to" address and EFT change requests.*

15 – Timeframes for Processing Enrollment Applications

(Rev. 134, Issued: 12-30-05; Effective/Implementation Dates: 03-01-06)

Timeliness expectations are not paramount over *the accurate processing of enrollment applications*. If an application requires developmental procedures not outlined in this manual, document and support any action you made within the file.

Processing the Initial Application (Including CHOWS, *Acquisitions/Mergers* and Consolidations *submitted by the new owner)*

Process *80* percent of applications within 60 calendar days of receipt; process *90* percent of applications within 120 calendar days of receipt; *process 99 percent of applications within 180 calendar days of receipt;* This process includes:

- Receipt of the application in *the contractor's* mailroom and forward*ing it* to *the* appropriate office for review;
- Prescreen*ing* the application in its entirety, as outlined in this section;
- Enter*ing* the information into PECOS;
- 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;
- Making a decision (or recommendation) to assign or deny a billing number;
- Formal notification of the *contractor's* decision *or recommendation* (and provid*ing* the appropriate appeal rights, as necessary); and
- Supplier site visit

Certified providers *and certified* suppliers are considered closed after the recommendation for approval/denial *is made*. *Specifically, the processing time clock ends on the date the recommendation letter is sent to the State (or, for providers for which the State agency has no involvement, the RO).*

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/*p*artnership 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 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. *Note that the timeliness clocks discussed in this section start on the date that 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.* 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 *should not* 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 *(Including CHOWs, Acquisitions/Mergers and Consolidations submitted by the old owner)*
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 *80* percent of the time. Process *90* percent of these applications within 60 days of receipt; *process 99 percent of these applications within 90 calendar days of receipt;*

This process includes:

- Receipt of the application in *the* mailroom and forward*ing it* to appropriate office for review;
- Review and verification of the changed information;
- Entering the information into PECOS;
- 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;
- Updating the system

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

- *Referring an application to the Payment Safeguard Contractor or the Office of the Inspector General;*
- *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/supplier to the Social Security Administration (SSA) in order to resolve a discrepancy with a Social Security Number (SSN), as explained in Sections 3.6 and 10.6 of this manual.*
- *Contacting Central Office (e.g., DPSE) or an RO's survey/certification staff with a question regarding the application in question or CMS policy.*

This mandate prohibiting clock stoppages and suspensions supersedes any previous or current instructions allowing for clock suspensions or stoppages in certain situations.

Despite the prohibition on clock stoppages/suspensions, the contractor should always document the file, identifying when the referral to CMS, 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. For instance, suppose 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. Yet the contractor should document its files to explain that it forwarded the question to CMS, the dates involved, and the reason for the referral.

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.

Prescreening

To better manage workloads, a prescreen of the application must be made within 15 calendar days of working an initial Form CMS-855I, Form CMS-855B, or Form CMS-855A. If the contractor is meeting timeliness standards, it is not necessary to prescreen. As *p*art 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 working the application. 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 *p*articipating 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 instructions and these chapter 10 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 further that:

- All Qualifier.net executive summaries are valid for 180 days.
- Qualifier.net does not verify SSNs. SSNs are verified via PECOS.
- Contractors may, but are not required to, run additional Qualifier.net searches on "AKA" names that appear on Qualifier.net.

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. CMS has 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.

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. *Be sure to document each contact and attempted contact with the provider, per the instructions in section 25 of this manual.*

Closing the Application

In situations where you have made at least three *consecutive* attempts to contact the applicant for information, and the applicant is not responding *whatsoever* to those requests, *you may* close the application *anytime on or after the 60th day of the processing cycle.* 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, *you may* close the file *on or after the 60th day.*

In addition, note the following concerning the closure of applications:

- *The ability to close an application on or after 60 days does not apply in those few situations where this chapter specifies an alternative closeout date (e.g., waiting for a final sales agreement);*
- *The 60-day closeout rule applies to changes of information as well as initial applications. Hence, the contractor may not close a change of information request until the 60th day, as opposed to the 45th day.*
- *To reemphasize: Except in those few situations specifically identified in this chapter , an application cannot be closed until three consecutive contacts (as described above) have been made and the provider has not responded to any of them. Moreover, if the provider resubmits at least some of the requested data to the contractor, this is considered a response (albeit not necessarily a complete one). Consider the following examples:*
  - *The contractor receives an initial enrollment application on March 1. It first contacts the provider with a request for four pieces of additional information on March 14. The contractor receives no response from the provider; it sends a second request for the data on March 24. Again, the provider fails to respond. On April 9, the contractor makes a final request for information. No reply is received for several weeks, and the contractor is prepared to close the application. On April 29 (the 59th day), however, the provider sends in two of the four requested pieces of information. As such, the contractor cannot close the application on April 30 because the provider at least partially responded to the contractor's request. In addition, it cannot close the application until the provider fails to respond to three consecutive requests for information. In other words, even a partial response to a request for information starts the "three strikes" process all over again.*

    Thus, suppose the contractor made another attempt to obtain additional information on May 10 but no response was received. The contractor cannot close the application until two more consecutive but unsuccessful attempts have been made.
  - *Using the example in the previous bullet, assume the contractor did not receive any information prior to April 30 and, as such, closed the application on April 30. The provider sent in all of the requested data on May 2. The contractor is under no obligation*

to re-open the provider's file, and the provider can be required to submit a brand new application.

- *Again using the example above, suppose the provider left a message with the contractor on April 29 stating, "We'll get this information to you as soon as we can." This technically does not qualify as a "response" because none of the requested data had been provided; hence, the contractor has the discretion to close the application on April 30 if the provider does not furnish the data by then. However, the contractor is encouraged to keep the file open so long as the provider shows at least some sort of willingness to provide the requested information.*

Other factual scenarios involving the closure of applications that are not specifically identified above should follow the same logic heretofore expressed.

For additional instructions regarding the closure of applications based on the failure to submit a sales agreement, see Section 10.1 of this chapter.

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."

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. *CMS* also suggest*s* 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 *CMS'* 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 applicant, 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.

Carrier Counting of Applications

In terms of "counting" applications, carriers should get one "count" for each application they process regardless of: (1) the type of application involved (e.g., CMS-855I, CMS-855R), (2) whether the forms arrived in a single package, or (3) whether the application in question was closed due to the provider's non-responsiveness. For instance, suppose a group practice is enrolling for the first time. It employs five doctors, all of whom will be reassigning their benefits to the group. The group thus submits in a single package one CMS-855B, five CMS-855Is, and five CMS-855Rs. The carrier should count this as 11 incoming applications; however, it should be sure to categorize them appropriately.