CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-08 Medicare Program Integrity	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 173	**Date: NOVEMBER 13, 2006**
	Change Request 5338

SUBJECT: Update to Chapter 10 –Medicare Provider/Supplier Enrollment

I. SUMMARY OF CHANGES: This change request updates a number of items in in Pub. 100-08, chapter 10 (hereinafter referred to as "chapter 10.") The most significant of these changes are as follows: First, a provider must submit a complete CMS-855 application if it is submitting any change request via the CMS-855 and is not in the Provider Enrollment, Chain and Ownership System (PECOS). Second, contractors shall establish a complete enrollment record in PECOS prior to approving or denying a CMS-855 application. Third, several other justifications for returning a CMS-855 application have been added to section 3.2 of chapter 10. Finally, a new section has been added to chapter 10 that describes in detail the various types of business organizations that contractors may encounter.

Contractors shall also note that sections 12.1, 12.2 and 12.3 have been deleted. They will be reincorporated into Chapter 10 in a future change request.

NEW / REVISED MATERIAL
EFFECTIVE DATE: *November 15, 2006
IMPLEMENTATION DATE: November 15, 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-*Only One Per Row.*

R/N/D	Chapter / Section / Subsection / Title
R	10/Table of Contents
R	10/1.3/Medicare Contractor Duties
R	10/2.1/Timeframes for Initial Applications
R	10/2.3/General Timeliness Principles
R	10/3.1/Pre-Screening Process
R	10/3.2/Returning the Application
R	10/4.1/Basic Information (Section 1 of the CMS-855)
R	10/4.2.1/Tax Identification Numbers and Legal Business Names

R	10/4.2.2/Licenses and Certifications
R	10/4.2.3/Correspondence Address
R	10/4.2.5/Section 2 of the CMS-855A
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	10/4.5/Owning and Managing Organizations
N	10/4.5.1/Types of Business Organizations
R	10/4.6/Owning and Managing Individuals
R	10/4.7/Chain Organizations
R	10/4.12/Special Requirements for Home Health Agencies (HHAs)
R	10/4.13/Contact Person
R	10/4.16/Delegated Officials
R	10/4.20/Processing CMS-855R Applications
R	10/4.21/National Provider Identifier (NPI)
R	10/5.2/Verification of Data
R	10/5.3/Requesting and Receiving Clarifying Information
R	10/5.5/Special Verification Procedures for CMS-855A Applications
R	10/5.7/Special Procedures for Processing Complete CMS-855 Applications Submitted by Enrolled Providers
R	10/6.2/Denials
R	10/7.1/General Procedures
N	10/7.1.1/Changes of Information and Complete CMS-855 Applications
R	10/7.3/Voluntary Terminations
R	10/8/Electronic Funds Transfers (EFT)
R	10/9/Revalidation
R	10/11.3/Provider-Based
R	10/11.6/Participation (Par) Agreements and the Acceptance of Assignment
R	10/11.7/Opt-Out
N	10/11.8/Manufacturers of Replacement Parts/Supplies for Prosthetic Implants or Implantable Durable Medical Equipment (DME) Surgically Inserted at an ASC
N	10/11.9/Enrolling Indian Health Service (IHS) Facilities as Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Suppliers
D	10/12/Provider and Supplier Types/Services

D	10/12.1/Community Mental Health Centers (CMHCs)
D	10/12.2/Diabetes Self-Management Training (DSMT)
D	10/12.3/Mass Immunizers Who Roster Bill
D	10/12.4/Enrolling Indian Health Service (IHS) Facilities as Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Suppliers
R	10/14/Model Correspondence Language
R	10/15/PECOS – General Information
N	10/15.1/PECOS Communication and Coordination
R	10/16/Reserved for Future Use
R	10/18.2/Provider Enrollment Inquiries
D	10/30/Provider Enrollment Disenrollment Actions
D	10/30.1/Deactivation of Billing Numbers
D	10/30.2/Contractor Issued Revocations
D	10/30.3/DPSE Issued Revocations
D	10/30.3.1/PSC Identified Revocations
D	10/30.3.2/CMS Satellite Office or Regional Office Identified Revocations

III. FUNDING:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2007 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: 173	Date: November 13, 2006	Change Request: 5338

SUBJECT: Update to Chapter 10—Medicare Provider/Supplier Enrollment

Effective Date: November 15, 2006

Implementation Date: November 15, 2006

I. GENERAL INFORMATION

A. Background: This change request updates a number of items in Pub. 100-08, chapter 10 (hereinafter referred to as "chapter 10"). The most significant of these changes are as follows. First, a provider must submit a complete CMS-855 application if it is submitting any change request via the CMS-855 and is not in the Provider Enrollment, Chain and Ownership System (PECOS). Second, contractors shall establish a complete enrollment record in PECOS prior to the approval or denial of a CMS-855 application. Third, several other justifications for returning CMS-855 applications have been added to section 3.2 of chapter 10. Finally, a new section has been added to chapter 10 that describes in detail the various types of business organizations that contractors may encounter.

B. Policy: A number of provider enrollment policy questions have arisen over the past 90 days that require additions to, and clarifications of, chapter 10.

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5338.1	Contractors shall require providers to submit a complete CMS-855 application if the provider is making any change to its current provider enrollment data and is not in PECOS.	X		X	X		X					
5338.2	Contractors shall establish a complete enrollment record in PECOS prior to the approval or denial (or recommendation for approval or denial) of a CMS-855 application.	X		X	X		X					
5338.3	Contractors shall not create separate PECOS enrollment records for home health agency (HHA) branches.	X		X			X					
5338.4	Contractors shall ensure that providers include their National Provider Identifier (NPI) notification each time the provider submits a CMS-855, even if the provider previously furnished the notification to the contractor.	X		X	X		X					National Supplier Clearinghouse
5338.5	Contractors shall no longer submit quarterly provider enrollment workload reports to the Division of Provider and Supplier Enrollment (DPSE), as had been previously required by section 16 of chapter 10.	X		X	X		X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	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 the space below: N/A

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 TITLE XVIII Contractors*****:** 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. We do 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 specified 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/Supplier Enrollment

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1.3– Medicare Contractor Duties

(Rev. 173; Issued: 11-13-06; Effective/Implementation Dates: 11-15-06)

Medicare fee-for-service contractors must adhere to the processing guidelines established in this chapter 10 (hereinafter generally referred to as "this manual"). In addition, fee-for-service contractors shall assign the appropriate number of staff to the Medicare enrollment function to meet established processing time frames.

Each Medicare fee-for-service contractor shall provide training to new employees and provide refresher training, as necessary, to existing employees to ensure that each employee processes enrollment applications in a timely, consistent, and accurate manner. Training shall include, at a minimum:

- An overview of the Medicare program*;*
- A review of applicable regulations, manual instructions and other guidance issued by CMS*;*
- A review of the contractor's enrollment processes and procedures*;* and
- Training regarding the Provider Enrollment, Chain and Ownership System (PECOS).

For new employees, each fee-for-service contractor shall also:

- Provide side-by-side training with an experienced provider enrollment analyst;
- Test the new employee to ensure that the analyst understands Medicare enrollment policy and contractor processing procedures, including the use of PECOS; and
- Conduct end-of-line quality reviews for 6 months after training or until the analyst demonstrates a clear understanding of Medicare enrollment policy and contractor procedures.

Conduct Prescreening

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

Conduct Verification, Validation, and Final Processing

- Verify and validate the information collected on the enrollment application.

- Coordinate with State survey/certification agencies and regional offices (ROs), as needed.

- Collect and maintain the application's certification statement (in house) to verify and validate Electronic Funds Transfer (EFT) changes. The change request signature must be checked against the original signature to determine the validity of any change to EFT information. This check can be made against a digital/photo image kept in-house. (See section 8 of this manual for more information.)

- Confirm that the applicant, all individuals and entities listed on the application, and any names or entities ascertained through the use of an independent verification source, are not presently excluded from the Medicare program by the HHS Office of the Inspector General (OIG). Contractors shall confirm and validate data through Qualifier.net, the Medicare Exclusion Database (MED), and the General Services Administration (GSA) debarment list, in accordance with existing CMS instructions and directives.

- Confirm that enrolled providers and suppliers are reviewed monthly against the MED. This is to ensure that billing privileges are not retained by providers/suppliers that become excluded after enrollment. *(This task only applies to carriers.)*

- Review and investigate provider/supplier reassignments of Medicare payments to ensure full compliance with operational guidelines.

Coordinate with other Contractors

- The NSC shall maintain a national master file of all durable medical equipment suppliers and share that information with the durable medical equipment regional contractors.

Use of and Establishment of Records in PECOS

- Establish, update and close provider and supplier records in PECOS.

2.1 – Timeframes for Initial Applications

(Rev. 173; Issued: 11-13-06; Effective/Implementation Dates: 11-15-06)

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 is not in PECOS,* (c) as part of a reactivation, or (d) as part of a revalidation. (See section 5.7 of this manual for more information on the processing of *"complete"* applications.)

2.3 - General Timeliness Principles

(Rev. 173; Issued: 11-13-06; Effective/Implementation Dates: 11-15-06)

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 Payment Safeguard Contractor (PSC) or the Office of the Inspector General (OIG);
- 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, 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, 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.)
- Changes of information submitted by an enrolled provider. (The first page of the application must be date-stamped.)
- Information furnished by the provider 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 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. 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, unless stated otherwise in this manual, 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. In addition, 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' 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.

3.1 – Pre-Screening Process

(Rev. 173; Issued: 11-13-06; Effective/Implementation Dates: 11-15-06)

A. Initial 15-Day Review

Within 15 calendar days after the application is received in the contractor's mailroom, the contractor shall complete a "pre-screen" of the application. The purpose of the pre-screening process is to ensure that the provider, at the time the application was originally submitted:

- Completed all required data elements on the application, regardless of the materiality of the data element or whether the information furnished is correct.

- Furnished all required supporting documentation – including, but not limited to, medical or professional licenses, certifications and registrations required by Federal or State law; NPI notification letters from NPPES; business licenses; IRS CP-575 documentation; interim sales agreements; etc. – needed to process the requested enrollment action.

If the provider: (1) files an application with at least one missing required data element, or (2) fails to submit all required supporting documentation, the contractor shall send a letter to the provider – preferably via e-mail or fax - that contains, at a minimum, the elements listed below. (The letter must be sent within the aforementioned 15-day period.)

- A list of all missing data or documentation;

- A request that the provider submit the data within a contractor-specified timeframe (i.e., the contractor can use whatever timeframe it wants, so long as it is within reason);

- The CMS Web site at which the CMS-855 forms can be found. The contractor shall instruct the provider to print out the page(s) containing the missing data; to enter the data on the blank page; to sign and date a new, blank certification statement; and to send it to the contractor. (As an alternative, the contractor can fax the blank page(s) and certification statement to the provider.) The provider need not furnish its initials next to the data element(s) in question.

  If the only missing material is documentation (i.e., all data elements have been completed), the contractor can forgo the activities in the previous paragraph. No newly-signed certification statement is required.

- A fax number and mailing address to which the missing data or documentation can be sent.

Note that the pre-screening letter is the only request for missing information or missing documentation that the contractor must make. Obviously, the contractor should respond to any of the provider's telephone calls, e-mails, etc., resulting from the pre-screening letter. However, the contractor need not – on its own volition – make an additional request for the missing data or documentation.

In addition:

- **Missing Information Available Elsewhere** – Even if the provider's application contains missing information that is nevertheless detected elsewhere on the form, in the supporting documentation, or on another enrollment form, the contractor must still send a pre-screening letter requesting the provider to furnish the missing data on the CMS-855. (An example would be if the provider neglected to furnish its zip code but the zip code is clearly indicated on a supporting document; another illustration would be if the provider failed to check the reason why the application was submitted yet it is patently obvious to the contractor that it is an initial enrollment.)

- **Unsolicited Submission of Data** - If the provider later submits the missing data on its own volition (i.e., without being contacted by the contractor) prior to the date the contractor finishes prescreening, the contractor shall include this additional data in its prescreening review.

- **Relationship to the Verification Process –** It is important that the contractor review section 5.3 of this manual for information on requesting additional (or "clarifying") information and how this is tied to the pre-screening process.

B. Rejection

In accordance with 42 CFR § 424.525(a), the contractor may reject the provider's application if the provider fails to furnish all of the information and documentation requested in the pre-screening letter within 60 calendar days of the contractor's request for the data.

The contractor shall also note the following with respect to rejections:

- ***PECOS*** *– The contractor shall create an L & T record within the 15-day period prescribed in sections 2.3 and 15 of this manual. If the contractor rejects the application and was unable to create an L & T record due to missing data, the contractor shall document the provider file accordingly. If the contractor was able to create the L & T record but rejected the application, the contractor shall flip the status to "rejected" in PECOS.*

- **Resubmission after Rejection** – If the provider's application is rejected, the provider must complete and submit a new CMS-855 and all supporting documentation.

- **Appeals** – The provider may not appeal a rejection of its enrollment application.

- **Policy Application –** Unless stated otherwise in this manual, the policies contained in this section 3.1 apply to all CMS-855 applications identified in sections 2.1 and 2.2 above (e.g., changes of information, reassignments). Thus, suppose an enrolled provider submits a CMS 588. If any information is missing from the form, the contractor shall send a pre-screening letter to the provider.

- **Good-Faith Effort by Provider** - If the provider fails to submit the requested data within the aforementioned 60-day timeframe but appears to be making a good-faith effort to do so, the contractor at its discretion may continue processing the application.

- **Incomplete Responses** – The provider must furnish all missing and clarifying data requested by the contractor within the applicable timeframe. Whether the provider indeed furnished all the information is a decision that rests with the contractor. Moreover, if the provider furnishes some, but not all, of the requested data within the 60-day period, the contractor is not required to contact the provider again to request the rest of the information. The contractor has the discretion to wait until the expiration of the 60-day period and then reject the application.

- **Notice of Rejection** – If the contractor rejects the application under this section 3.1, it shall notify the provider via letter or e-mail that the application is being rejected, the reason(s) for the rejection, and how to reapply. The contractor is free to keep the original application on file after rejection. If the provider requests a copy of its application, the contractor may fax it to the provider.

- **Documentation** – The contractor shall document in the file the date on which it completed its pre-screening of the application.

- **Commencement of Timeframe** – The 60-day clock described above commences when the contractor mails, faxes, or e-mails the pre-screening letter.

- **Acknowledgment of Receipt** – The contractor may, but is not required to, send out acknowledgment letters.

- **"Not Applicable"** - It is unacceptable for the provider to write "N/A" in response to a question that requires a "yes" or "no" answer. This is considered an incomplete reply, thus warranting the issuance of a pre-screening letter based on missing information.

- ***"Pending"*** *– "Pending" is an acceptable response, requiring no further development, in the following situations:*

  - ***Section 2B2 of the CMS 855*** *- The license or certification cannot be obtained until after a State survey is performed or RO approval is granted.*

  - ***Section 4 of the CMS 855*** *- The license/certification cannot be obtained (or the practice location cannot be considered fully established) until after a State survey is performed or RO approval is granted.*

  - *New enrollees who have no Medicare billing number can write "pending" in the applicable "Medicare Identification Number" boxes. (This policy, however, does not apply to NPIs.)*

- **Licensure** - For certified suppliers and certified providers, there may be instances where a license may not be obtainable until after the State conducts a survey. Since the license is therefore not "required," the contractor shall not consider this to be "missing" information or documentation.

- **Section 6** – If an authorized or delegated official is not listed in section 6 of the CMS-855, this qualifies as an incomplete application and thus triggers the need for a pre-screening letter.

To summarize, if - during the pre-screening process - the contractor finds that data or documentation is missing, it shall send a pre-screening letter the provider within the 15-day pre-screening period. The provider must furnish all of the missing material within 60 calendar days of the request. If the provider fails to do so, the contractor shall reject the application.

3.2 – Returning the Application

(Rev. 173; Issued: 11-13-06; Effective/Implementation Dates: 11-15-06)

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 the forms needed to process a reassignment package within 15 calendar days of receipt (as described 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 not mailed in (i.e., it was faxed or e-mailed).
- *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, ambulatory surgical centers, 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.

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.

- 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).

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.

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.)

See section 7.1.1 of this manual for information on how contractors shall process complete CMS-855 applications submitted by enrolled providers who are not in PECOS.

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

(Rev. 173; Issued: 11-13-06; Effective/Implementation Dates: 11-15-06)

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 the NPI are correct. (The NPI can be verified by reviewing the NPI notification from NPPES.)

Note that:

- If a provider is seeking to reestablish itself in the Medicare program after reinstatement from an exclusion, the provider must enroll as if it were an initial enrollment.

- Hospitals that are requesting enrollment with the carrier to bill 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. Thus, suppose a supplier is changing its TIN. It must enroll as a new supplier while also requesting to terminate its existing billing number. The provider must submit two applications: (1) an initial CMS 855B for the 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 – Tax Identification Numbers and Legal Business Names

(Rev. 173; Issued: 11-13-06; Effective/Implementation Dates: 11-15-06)

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).

Discussed below are the procedures for verifying the EINs and SSNs of all entities and persons listed on the CMS-855. An application cannot be approved until all TINs (whether EINs or SSNs) listed on the application have been furnished and properly validated.

Employer Identification Numbers

- *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 require 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 of the articles of incorporation, 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.

Social Security Numbers

The PECOS will verify all SSNs listed on the application and entered into the system. Contractors shall not require the applicant to submit SSN tax documentation or social security cards at any point in the verification process. (Additional documentation need only be submitted when the person is doing business using a number other than its SSN. For example, an individual who forms a professional corporation or a sole proprietor who requests to use his/her EIN to receive Medicare payments must submit the IRS documentation described above.)

If the SSN in PECOS shows "The SSN unverified", the contractor shall request additional information. (This may clarify which data element is causing the rejection.) If the contractor determines that a number was transposed or otherwise receives a rational reason for the number not matching, it shall obtain the correct SSN and continue processing the application. If the contractor cannot resolve the case, the contractor may either (1) deny the application at that point, or (2) refer the applicant and/or the owner/manager in question to the SSA. If the latter option is chosen, the contractor shall deny the application if the individual has not resolved the matter with the SSA within a sufficient period of time. (The contractor has the sole discretion to determine what constitutes a "sufficient" period.)

NOTE: One common reason a SSN does not match is because the SSA may not have the correct surname. In situations where a female has changed her surname but has not contacted the SSA, PECOS will not validate the information. The contractor shall determine if this is the cause for the error message. If the applicant can furnish a surname used previously, the contractor shall check to see if PECOS will accept the surname. It shall also look at Qualifier.net to determine if this surname was used previously. If it was, the contractor shall continue processing the application using the previously used surname. However, the name is still required to be matched in PECOS and the matching surname must be the one listed on the CMS-855. (This may require a new certification statement. The contractor shall inform the applicant that he/she must change his/her name with the SSA. When this has been done, the CMS-855 must be updated to reflect the SSA change.)

The verification of the SSN is a process separate from the verification of the date of birth (DOB). Thus, if the SSN is verified but the DOB is not, the SSN is still considered verified for enrollment purposes. Conversely, even if the DOB is verified, the SSN must still be independently validated.

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 form.

- 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.)

Owners and Managers

All instances described in this section 4.2.1 where the contractor should deny the application also apply to owners, managers, etc., not just the applicant. Moreover, if an owner/manager's SSN cannot be verified and a denial is warranted, the contractor shall not give the provider the option to terminate that individual and then proceed with its existing enrollment. The provider will have to submit a new enrollment application and furnish proof acceptable to the contractor that the person no longer has a connection with the provider.

Certified Providers

There is no prohibition against two or more certified providers having the same TIN. (For instance, 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. 173; Issued: 11-13-06; Effective/Implementation Dates: 11-15-06)

The question of to what extent 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.

Carriers

The carrier 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 carrier'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 carrier, in its general review of Qualifier.net, finds inconsistencies between the data on the license and the data in Qualifier.net, the carrier 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 carrier 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 carrier shall still ensure, however, that the supplier meets all applicable State and Medicare requirements.

In addition, the carrier shall 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 carrier need not verify licenses, certifications, and accreditations submitted by ASCs and portable x-ray suppliers. Instead, the carrier 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 provider for the licensing and/or certification data and enter it into PECOS.

- **Notarization:** If the applicant submits a license that is not notarized or "certified true," the carrier shall verify the license with the appropriate State agency. (A notarized copy of an original document has a stamp that States "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.)

  If the State has a licensing body that issued the applicant a certificate of good standing, the carrier shall recognize it as adequate proof that the supplier has received the license required. However, the certificate of good standing cannot be older than 30 days.

- **Temporary Licenses:** If the supplier submits a temporary license, the carrier shall note the expiration date in PECOS. Should the supplier fail to submit the permanent license after the temporary license expiration date, the carrier 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 carrier 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 carrier on May 1, and the carrier approves the application on June 1. The date of enrollment is June 1, not January 1. (Note that the issue of the date of enrollment is separate from the question of from what date the supplier may bill.)*

- *Even if the supplier furnishes the requested licensure and certification data in section 2 of the CMS-855, it must still submit a copy of all licenses and certifications.*

Fiscal Intermediaries

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

The intermediary 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 licensing and/certification data and enter it into PECOS.

4.2.3 – Correspondence Address

(Rev. 173; Issued: 11-13-06; Effective/Implementation Dates: 11-15-06)

This must be an address where the contractor can directly contact the applicant to resolve any issues that may arise as a result of his/her/its enrollment in the Medicare program. It cannot be the address of a billing agency, management services organization, or the provider's representative (e.g., attorney, financial advisor). It can, however, be a P.O. Box or, in the case of individual practitioners, 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. Contractors only need to verify that the applicant can be reached at this number.

4.2.5 – Section 2 of the CMS-855A

(Rev. 173; Issued: 11-13-06; Effective/Implementation Dates: 11-15-06)

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 fiscal intermediary chooses to permit this notification to be made via the CMS-855A, the fiscal intermediary 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 intermediary shall document that such notice was given.

HHA Branches, Hospital Units, and Outpatient Physical Therapy/Occupational Therapy (OT/PT) Extension Sites

A branch is a location or site from which an HHA provides services within a portion of the total geographic area served by the parent agency. The branch is part of the HHA and is located sufficiently close to the parent agency so that it shares administration, supervision, and services with the parent agency. If an existing HHA wishes to add a branch, it is considered a change of information on the CMS-855.

A subunit is a semi-autonomous organization under the same governing body as a parent HHA that serves patients in a geographic area different from that of the parent agency. The parent agency, because of the distance between it and the subunit, is incapable of sharing administration, supervision and services with the subunit on a daily basis. 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 OT/PT 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 fiscal intermediary shall make a recommendation for approval or denial and forward the package to the State and RO. However, the fiscal intermediary shall also 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 intermediary shall create a separate enrollment record for the *hospital unit. However, a separate enrollment record for each HHA branch is not required. These locations can simply be listed on the main provider's enrollment record.*

Critical Access Hospitals

Critical access hospitals (CAHs) are not considered to be a hospital sub-type for enrollment purposes. Thus, if a type of hospital under section 2A2 of the CMS-855A wishes to convert to a CAH, it must complete a whole new CMS-855A as an initial enrollment.

4.2.7 – Section 2 of the CMS-855I

(Rev. 173; Issued: 11-13-06; Effective/Implementation Dates: 11-15-06)

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

The carrier 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 carrier 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 carrier. The carrier can verify this information via a State licensure/certification Web site or other mechanism.

C. *Resident/Intern* Status

If the applicant is a "resident" (as defined at 42 CFR § 413.75(b)) in an "approved medical residency program" (as defined at § 413.75(b)), the contractor shall refer to Pub. 100-2, 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 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 carrier 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 be entered into PECOS as well. If an employer is excluded or debarred, the carrier shall deny the application.

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

E. Nurse Practitioners

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

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

F. Clinical Psychologists (CPs)

If the applicant does not hold a doctoral degree in psychology, the carrier shall deny the application. Note that there are three different types of doctoral degrees in psychology that meet Medicare's requirements:

1. Ph.D. (doctorate of philosophy degree) – This is the most common degree. The Ph.D. must be in psychology (as opposed to any other subject area). If the degree does not state "Doctor of Philosophy" followed by some specific subject area of psychology, the carrier shall follow the instructions below for verifying the doctorate.

2. Psy.D. (doctorate of psychology degree) - This degree is granted by programs that lean more heavily towards preparing students for clinical practice rather than research or teaching.

3. Ed.D. (doctorate of education degree) - The person's Ed.D. must be in psychology. To illustrate, having an Ed.D. in Counseling Psychology would qualify someone to seek CP status, but having an Ed.D. in educational administration or curriculum design would not. If the degree does not state "Doctor of Education" followed by some specific subject area of psychology, the carrier shall follow the instructions below for verifying the doctorate.

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

1. The carrier can check with the licensing board in each State to determine whether a doctorate in psychology is required to obtain a license to practice as a clinical psychologist. The majority of States require this level of education in order to practice psychology independently. If the carrier finds that the State requires a doctorate in psychology as a requirement for licensure as a clinical psychologist, the carrier may take the fact that the applicant has a license, along with the copy of the degree, as sufficient evidence that the applicant meets Medicare's educational requirements for a clinical psychologist. (This is the preferred method to verify that the applicant meets Medicare's educational requirements.) If the carrier chooses this method of verification, it must document in its procedures that the State licensure requirements for clinical psychologists require a doctorate in psychology. By doing so, the carrier will not need to repeat this task in the future.

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

If the applicant indicated in section 2D that he/she is a clinical psychologist but checks "no" in section 2H, the carrier shall deny the application.

G. Psychologists Billing Independently

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

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

If the applicant indicates that this is his/her specialty, he/she must respond to these questions. 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. This information will be captured through the group application.

With respect to the questionnaire in section 2J:

- If the OT/PT checks that he/she renders all of his/her services in patients' homes, the carrier 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 PT/OT services. If no such lease exists, the carrier shall deny the application.

4.3 – Adverse Legal Actions/Convictions

(Rev. 173; Issued: 11-13-06; Effective/Implementation Dates: 11-15-06)

(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 referring the issue 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 CMS issues a final directive on the matter to the contractor.

If the applicant is excluded or debarred, the contractor shall deny the application in accordance with the instructions in this manual; it need not refer the matter to DPSE prior to issuing the denial. 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. 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) indicating 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 CMS for further instructions. The contractor shall neither approve nor deny the application until CMS issues a final directive on the matter to the contractor, which could include an instruction to deny the application based on false information furnished by the applicant. (See section 6.2 of this manual.)

In any situation where CMS directs the contractor to deny an application based on an adverse legal action, the contactor shall notify 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 outlined in this section 4.3.

4.4 – Practice Location Information

(Rev. 173; Issued: 11-13-06; Effective/Implementation Dates: 11-15-06)

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. If a particular practice 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.

NOTE: The practice location name may be the "doing business as" name.

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 a number 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, however, 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 and portable x-ray suppliers, the carrier 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 is approved and had a valid license as of the date listed.) In situations where the date listed appears to be beyond a reasonable amount of time (e.g., older than 12 months), the carrier shall contact the applicant by telephone and request clarifying information; it needs to ensure that the 12-month deactivation initiative will not remove the applicant from the file for any date that is used.

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 as written in Pub. 100-04, chapter 1, section 80.5. Returned mail in the form of remittance advices and checks shall be flagged if returned from the post office, as it indicates that a change of the *provider's* "special payment" address (section 4 of the CMS-855) has occurred. The *provider* should thus submit a CMS-855 request to change this address; if the *provider* has never completed *an entire* CMS-855 application before, it must do so at that time.

Returned mail received from the post office box that is not a remittance advice or check is not considered to be DNF mail.

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 still 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 supplier 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 Electronic Funds Transfer (EFT). The contractor shall thus ensure that the provider has signed the EFT Authorization Agreement (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 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 may be made - might be in violation of the Payment to Agent rules in Pub. 100-04, chapter 1, section 30.2.

- *The chain home office address. Per Pub. 100-4, chapter 1, section 30.2, a chain organization may have payments to its providers sent to the chain home office.*

4.5 – Owning and Managing Organizations

(Rev. 173; Issued: 11-13-06; Effective/Implementation Dates: 11-15-06)

(This section only applies to section 5 of the CMS-855A and CMS-855B. It does not apply to the CMS-855I.)

All organizations that have any of the following must be listed in section 5A of the CMS-855:

1. A 5 percent or greater direct or indirect ownership interest in the provider.

The following example illustrates the difference between direct and indirect ownership:

The supplier listed in section 2 of the CMS-855B is an ambulance company that is wholly (100 percent) owned by Company A. Here, Company A is considered to be a direct owner of the supplier (the ambulance company), in that it actually owns the assets of the business. Now assume that Company B owns 100 percent of Company A. Company B is considered an indirect owner - but an owner, nevertheless - of the supplier. In other words, a direct owner has an actual ownership interest in the supplier, whereas an indirect owner has an ownership interest in an organization that owns the supplier.

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

(a) An organization or individual is the owner of a whole or part interest in any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by the provider or any of the property or assets of the provider, and

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

2. A partnership interest in the provider, regardless of: (1) the percentage of ownership the partner has, and (2) whether the partnership interest is that of a general partner or a limited partner (e.g., all limited partners in a limited partnership must be listed in section 5A).

3. Managing control of the provider.

A managing organization is one that exercises operational or managerial control over the provider, or conducts the day-to-day operations of the provider. The organization need not have an ownership interest in the provider in order to qualify as a managing organization. For instance, the organization could be a management services

organization under contract with the provider to furnish management services for one of the provider's practice locations.

Contractors shall also note the following regarding owning and managing organizations:

- Such organizations generally fall into one of the following categories: (1) corporations (including non-profit corporations); (2) partnerships and limited partnerships; (3) limited liability companies; (4) charitable and religious organizations; (5) governmental/tribal organizations.

- Any entity listed as the applicant in section 2 of the CMS-855 need not be reported in section 5A. The only exception to this involves governmental entities, which must be listed in section 5A even if they are already listed in section 2.

- With respect to governmental organizations, the letter referred to in the CMS-855 form instructions for section 5 must be signed by an appointed or elected official of the governmental entity who has the authority to legally and financially bind the government to the laws, regulations, and program instructions of Medicare. There is no requirement that this government official also be an authorized official, or vice versa.

- Many non-profit organizations are charitable or religious in nature, and are operated and/or managed by a Board of Trustees or other governing body. The actual name of the Board of Trustees or other governing body should be listed in section 5A of the CMS-855. The applicant should submit a copy of its 501(c)(3) approval notification for non-profit status. If it does not possess such documentation but nevertheless claims it is a non-profit entity, the applicant may submit any other documentation that supports its claim, such as written documentation from the State, etc. This documentation is necessary if the applicant does not list any owners in section 5 or section 6 of the application.

- The contractor shall review all organizations listed in section 5A against Qualifier.net. If an adverse legal action is found, the contractor shall follow the instructions in section 4.3 of this manual.

- Owning/managing organizations need not submit an IRS CP-575 document unless requested by the contractor *(e.g., the contractor discovers a potential discrepancy between the organization's legal business name and tax identification number in Qualifier.net.)*

- All owning and managing organizations listed in section 5 of the CMS-855 must be entered into PECOS.

4.5.1 – Types of Business Organizations

(Rev. 173; Issued: 11-13-06; Effective/Implementation Dates: 11-15-06)

This section explains the legalities of various types of business organizations that may enroll, including sole proprietorships. Note that the type of business structure a provider has can have a major impact on its enrollment.

Business organizations are generally governed by State law. Thus, State X may have slightly different rules than State Y regarding certain entities. (In fact, X may allow special types of entities to exist that Y does not.) The discussion below only gives a broad overview of the above-listed business types and does not take into account different State nuances.

A. Corporations

A corporation is an entity separate and distinct from its owners, who are called stockholders (or shareholders). To form a corporation, various documents – such as articles of incorporation – must be filed with the State in which it wants to incorporate. The key elements of a corporation are:

- *Limited Liability – This is the biggest reason why a business chooses to operate as a corporation. Suppose Corporation X has ten stockholders, each owning 10% of the business. X breached a contract it had with Company Y, and now Y wants to sue X's owners. Unfortunately for Y, it can really only sue X itself – it cannot go after its owners. In other words, the corporation's owners are essentially shielded from liability for the actions of the corporation because, as stated above, a corporation is separate and distinct from its owners.*

  Despite the concept of limited liability, there may be instances where a corporation's owners/stockholders can be held personally liable for the corporation's debts. This process is known as ***"piercing the corporate veil"*** *(PCV), whereby one tries to get past the brick wall of the corporation in order to collect money from the owners behind that wall. However, PCV is a difficult thing to do and many courts are unwilling to allow it, meaning that plaintiffs can only collect from the corporation itself.*

- *Double Taxation – This is the biggest reason why a business may choose not to be a corporation. Double taxation means that (1) the corporation itself must pay taxes AND (2) each shareholder must pay taxes on any dividends he/she receives from the business.*

- *Board of Directors – Most corporations are run by a governing body, usually called a Board of Directors.*

Two special types of corporations contractors may encounter are:

- ***"Professional Corporation,"*** *or "PC." In general, a PC: (1) is organized for the sole purpose of rendering professional services (such as medical or legal), and (2) all stockholders in the PC must be licensed to render such services. Thus, if A, B and C want to form a physician practice (each is a 1/3 stockholder) and only A is a medical professional, the PC probably cannot be formed (depending, of course, on what the applicable State PC statute says). In addition, the title of a PC will usually end in "PC," "PA" (Professional Association) or "Chartered."*

- ***"Close" Corporation*** *(or "closely-held" corporation) – This is a type of corporation with a very limited number of stockholders. Unlike a "regular" corporation, the entity's board of directors does not generally run the business; rather, the shareholders do. The stock is typically not sold to outsiders.*

Although PCs and CCs are considered "corporations" for enrollment purposes, State laws governing these entities are often different from those that govern "regular" corporations. (That is, States have separate statutes for "regular" corporations and for PCs/CCs.) In many cases, an entity must specifically elect to be a PC or CC when filing necessary paperwork with the State.

B. <u>Partnerships</u>

A partnership is an association of two or more persons/entities who carry on a business for profit. Each partner in a partnership is an owner. If A and B form the "Y Partnership" and each contributes $50,000 to start up the business, each partner would own one-half of Y.

In several aspects, a partnership is the opposite of a corporation:

- *Each partner is liable for all the debts of the partnership. Using the example above, suppose the Y Partnership breached a contract it had signed with Mr. X, who now sues for $10,000. Since each partner is liable for all debts, X can collect the entire $10,000 from A, or from B, or $5,000 from each, etc. This is because, unlike a corporation, a partnership is not really a separate and distinct entity from its partners/owners – that is, the partners <u>are</u> the partnership. If Y had been a corporation, the owners (A and B) would generally be shielded from liability.*

- *There is no "double taxation" with partnerships. The partnership itself does not pay taxes, although each partner pays taxes on any income they earn from the business.*

- *Unlike a corporation, a partnership generally does not file papers with the State upon its creation (i.e., it does not file the equivalent of articles of incorporation). Instead, a partnership has a "partnership agreement," which is nothing more than a contract between the partners outlining duties, responsibilities, powers, etc.*

- *Each partner has the right to participate in running the business's day-to-day operations, unless the partnership agreement dictates otherwise.*

*An alternative type of partnership is a **limited partnership** (as opposed to a "general partnership," described above). While possessing many of the characteristics of a general partnership, there are some key differences. First, a limited partnership (LP) must file formal documents with the State. Second, a LP has two kinds of partners – general and limited. The general partner(s) runs the business, yet is personally responsible for all of the LP's debts. Conversely, the limited partner(s) have limited liability yet cannot participate in the management of the business.*

C. Limited Liability Companies (LLC)

A limited liability company (LLC) is a legal entity that is neither a partnership nor a corporation, but has characteristics of both. Its owners have limited liability (just like stockholders in a corporation). In addition, the LLC does not pay Federal taxes (similar to a partnership), although its owners – usually referred to as "members" - must pay taxes on any dividends they reap. An LLC thus contains the best attributes of corporations and partnerships, which is why LLCs are rapidly gaining in popularity.

An LLC should not be confused with a limited liability corporation, which is a type of corporation in some States. A limited liability company is not a corporation or partnership, but a distinct legal entity created and regulated by special State statutes.

Note that certain CMS 855 information is required of different entities. The primary example of this is in section 6 (Managing Individuals). If the provider is a corporation, it must list its officers and directors on the form. Partnerships and LLCs, on the other hand, do not have officers or directors and thus need not list them.

D. Joint Ventures

A joint venture is when two or more persons/entities combine efforts in a business enterprise and agree to share profits and losses. It is very similar to a partnership (and is treated as a partnership for tax purposes). The key difference is that a partnership is an ongoing business, while a joint venture is a temporary, one-time business undertaking. A joint venture, therefore, can be classified as a "temporary partnership."

E. Non-Profit Organizations

The term "non-profit organization" is misleading. It is not an organization that is forbidden to make a profit. Rather, it means that all profits are put back into the entity to promote its goals, which are usually political, social, religious, or charitable in nature. In other words, the NPO is not organized primarily for profit, but instead to further some other goal. An entity can acquire NPO status by obtaining a 501(c)(3) certification from the IRS (meaning it is tax-exempt) or by acquiring such status from the State it is located in.

NPO status is important for enrollment purposes because NPOs generally do not have owners. Thus, a NPO need not list any owners in sections 5 or 6 of the CMS 855.

F. Sole Proprietorships

A business is a sole proprietorship if it meets each of the following criteria:

- *It files a Schedule C (1040) with the IRS (this form reports the business's profits/losses)*
- *One person owns all of the business's assets*
- *It is not incorporated*

A sole proprietorship is not a corporation. Suppose a physician operates his/her business as a home health agency. If he/she incorporates his/her business, the business becomes a corporation (even though the physician is the only stockholder). Thus, the frequently-used term "unincorporated sole proprietorship" is a misnomer, because sole proprietorships by definition are unincorporated. In addition, merely because the sole proprietor hires employees does not mean that the business is no longer a sole proprietorship. Assume W is a sole proprietor and he hires X, Y, and Z as employees. W's business is still a sole proprietorship because he is still the 100% owner of the business. If W had sold parts of his sole proprietorship to X, Y, and Z (as opposed to just hiring them), the business would no longer be a sole proprietorship, as there is now more than one owner.

G. Government-Owned Entities

For purposes of enrollment, a government-owned entity (GOE) exists when a particular government body (e.g., Federal, State, city or county agency) will be legally and financially responsible for Medicare payments received. For example, suppose Smith County operates Hospital X. Medicare overpaid X $100,000 last year. If Smith County is the party responsible for reimbursing Medicare this amount, X is considered a government-owned entity.

Note that:

- *GOEs do not have "owners." Thus, section 5 of the CMS 855 need only contain the name of the government body in question. Using our example above, this would be Smith County.*

- *For section 6 (Managing Individuals), the only people that need to be listed are "managing employees." This is because GOEs do not really have officers or directors.*

- *The entity must submit a letter from the government body certifying that the government will be responsible for Medicare payments.*

4.6 – Owning and Managing Individuals

(Rev. 173; Issued: 11-13-06; Effective/Implementation Dates: 11-15-06)

(This section applies to section 6 of the CMS-855A, the CMS-855B, and the CMS-855I.)

All individuals who have any of the following must be listed in section 6A:

1. A 5 percent or greater direct or indirect ownership interest in the provider. (See section 4.5 of this manual for information on the distinction between direct and indirect ownership, as well as the definition of "financial control.")

2. A partnership interest in the provider, regardless of: (1) the percentage of ownership the partner has, and (2) whether the partnership interest is that of a general partner or a limited partner (e.g., all limited partners in a limited partnership must be listed in section 6A).

3. Managing control of the provider. (For purposes of enrollment, such a person is considered to be a "managing employee." A managing employee is any individual, including a general manager, business manager, office manager or administrator, who exercises operational or managerial control over the provider's business, or who conducts the day-to-day operations of the business. A managing employee also includes any individual who is not an actual W-2 employee but who, either under contract or through some other arrangement, manages the day-to-day operations of the business.)

In addition:

- "Officers" and "directors", as those terms are defined on the CMS-855 form instructions for section 6, need only be reported if the applicant is a corporation. (For-profit and non-profit corporations must list all of their officers and directors; if a non-profit corporation has "trustees" instead of officers or directors, these trustees must be listed in section 6.)

- Government entities need only list their managing employees in section 6, as they do not have owners, partners, corporate officers, or corporate directors.

- The applicant must list at least one managing employee in section 6 if it is completing the CMS-855A or the CMS-855B. A practitioner completing the CMS-855I need not list a managing employee if he/she does not have one.

- With respect to the CMS-855I only, all managing employees at any of the applicant's practice locations listed in section 4C of the CMS-855I must be reported in section 6A. However, individuals who: (1) are employed by hospitals, health care facilities, or other organizations shown in section 4C (e.g., the CEO of a hospital listed in

section 4C) or (2) are managing employees of any group/organization to which the practitioner will be reassigning his/her benefits, should not be reported.

- The contractor shall review all individuals listed in section 6A against Qualifier.net. If an adverse legal action is found, the contractor shall follow the instructions in section 4.3 of this manual.

- All owners and managers listed in section 6 of the CMS-855 must be entered into PECOS. Any previous policy that permitted contractors to enter only one managing individual into PECOS for purposes of creating an enrollment record is discontinued.

- Information on processing section 6B (Adverse Legal Actions) can be found in section 4.3 of this manual. Additionally, instructions on how to verify the individual's SSN can be found in section 4.2.1.

- *It is not necessary for the contractor to request a copy of the person's W-2 to confirm that he/she is in fact a W-2 employee (as opposed to a contracted employee).*

4.7 – Chain Organizations

(Rev. 173; Issued: 11-13-06; Effective/Implementation Dates: 11-15-06)

(This section only applies to the CMS-855A. It is inapplicable to the CMS-855B and the CMS-855I.)

All providers that are currently part of a chain organization or who are joining a chain organization must complete this section with information about the chain home office. A chain organization exists when multiple providers/suppliers are owned, leased, or through any other devices, controlled by a single business entity. This entity is known as the chain home office.

At the current time, the fiscal intermediary shall not hold up the processing of the provider's application while awaiting the issuance of a chain home office number (i.e., a determination as to whether a set of entities qualifies as a chain organization). Such an issuance/determination is not presently required prior to the intermediary making its recommendation for approval or denial.

The fiscal intermediary shall ensure that:

- The chain home office is identified in section 5A of the CMS-855A and that adverse legal action data is furnished in section 5B. (The chain home office automatically qualifies as an owning/managing organization.) *Note than an NPI is typically not required for a chain home office.*

- The chain home office administrator is identified in section 6A of the CMS-855A and that adverse legal action data for the administrator is furnished in section 6B.

The fiscal intermediary shall review both the chain home office and its administrator against Qualifier.net. If an adverse legal action is found, the contractor shall follow the instructions in section 4 of this manual.

4.12 – Special Requirements for Home Health Agencies (HHAs)

(Rev. 173; Issued: 11-13-06; Effective/Implementation Dates: 11-15-06)

(This section only applies to the CMS-855A.)

The fiscal intermediary shall verify that the HHA meets all of the capitalization requirements addressed in 42 CFR § 489.28. The fiscal intermediary may request from the provider any and all documentation deemed necessary to perform this task. Failure to meet the capitalization requirements shall result in a recommendation for denial.

If the HHA checks "yes" in section 12B, the contractor shall review the HHA nursing registry and the tax identification number against Qualifier.net. *(A nursing registry is akin to a staffing agency, whereby a private company furnishes nursing personnel to hospitals, clinics, and other medical providers.)*

4.13 – Contact Person

(Rev. 173; Issued: 11-13-06; Effective/Implementation Dates: 11-15-06)

The contractor shall contact the individual listed in this section if it has questions regarding *the provider's application.* If the applicant does not list or otherwise specify a contact person, the contractor shall call an authorized or delegated official. (In the case of the CMS-855I, the carrier shall contact the applicant himself/herself.) 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.

4.16 – Delegated Officials

(Rev. 173; Issued: 11-13-06; Effective/Implementation Dates: 11-15-06)

(This section only applies to the CMS-855A and the CMS-855B.)

A delegated official is an individual who is delegated by an 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.

Section 1124(a)(3) defines an individual with an ownership or control interest as:

- A five percent direct or indirect owner of the provider,
- An officer or director of the provider, if the provider is a corporation, or
- A partner of the provider, if the provider is a partnership

The individual must have been delegated the legal authority by an authorized official listed in section 15 to make changes and/or updates to the provider's status in the Medicare program, and to commit the provider to fully abide by the laws, regulations, and program instructions of Medicare.

Contractors shall note the following about delegated officials:

- A delegated official has no authority to sign an initial enrollment application or a revalidation application. The primary function of a delegated official is to sign off on changes of information. However, the changes and/or updates that may be made by delegated officials include situations where the provider is contacted by the contractor to clarify or obtain information needed to continue processing the provider's initial CMS-855 application.
- For purposes of section 16 only, the term "managing employee" means any individual, including a general manager, business manager, or administrator, who exercises operational or managerial control over the provider, or who conducts the day-to-day operations of the provider. However, this does <u>not</u> include persons who, either under contract or through some other arrangement, manage the day-to-day operations of the provider but who are not actual W-2 employees. For instance, suppose Joe Smith is hired as an independent contractor by the provider to run its day-to-day-operations. Under the definition of "managing employee" for section 6 of the CMS-855, Smith would have to be listed. However, under the section 16 definition (as described above), Smith cannot be a delegated official because he is not an actual W-2 employee of the provider. Independent contractors are not considered "managing employees" under section 16.

The provider is not required to submit a copy of the owning/managing individual's W-2 to verify an employment relationship, unless requested by the contractor.

- All delegated officials must be reported in section 6 of the CMS-855.

- The provider can have as many delegated officials as it wants. Conversely, the provider is not required to have any delegated officials at all. Should no delegated officials be listed, however, the authorized official(s) remains the only individual(s) who can make changes and/or updates to the provider's status in the Medicare program.

- The effective date in PECOS for section 16 should be the date of signature.

- In order to be a delegated official, the person must have and must submit his/her social security number.

- If a delegated official is being deleted, documentation verifying that the person no longer is or qualifies as a delegated official is not required, nor is the signature of the deleted official needed.

- Delegated officials may not delegate their authority to any other individual. Only an authorized official may delegate the authority to make changes and/or updates to the provider's Medicare status.

- If the provider is submitting a change of information (e.g., new practice location, change of address, new part-owner) and the delegated official signing the form is not on file, the contractor shall ensure that: (1) the person meets the definition of a delegated official, (2) section 6 of the CMS-855 is completed for that person, and (3) an existing authorized official signs off on the addition of the delegated official. Note that the original change request and the addition of the new official shall be treated as a single change request (i.e., the change request encompasses two different actions).

- The delegated official must be a delegated official of **the provider**, not of an owning organization, parent company, or management company.

4.20 – Processing CMS-855R Applications

(Rev. 173; Issued: 11-13-06; Effective/Implementation Dates: 11-15-06)

A CMS-855R application must be completed for any individual who will:

- Reassign his/her benefits to an eligible entity.
- Terminate an existing reassignment.

If the individual who wants to reassign his or her benefits is not enrolled in Medicare, the person must complete a CMS-855I as well as the CMS-855R. (The CMS-855I and CMS-855R can be submitted concurrently.) In addition, the newly enrolling entity that is going to receive benefits must complete a CMS-855B. (See section 5.4 for additional instructions regarding the joint processing of CMS-855Rs, CMS-855Bs, and CMS-855Is.)

Note that benefits are reassigned to a supplier, not to the practice location(s) of that supplier. As such, carriers shall not require each practitioner in a group to submit a CMS-855R each time the group adds a practice location.

In addition:

- An individual can receive reassigned benefits. The most common example of this is a physician or practitioner who reassigns his/her benefits to a physician who is either: (1) a sole proprietor, or (2) the sole owner of an entity listed in section 4A of the CMS-855I. Here, the only forms that will be required are the CMS-855R, and CMS-855Is from the reassignor and the reassignee. (No CMS-855B is implicated.) The reassignee himself/herself must sign section 4B of the CMS-855R, as there is no authorized or delegated official involved.
- The carrier shall follow the instructions in Pub. 100-04, chapter 1, section 30.2 to ensure that the group or person is eligible to receive reassigned benefits.
- If the individual is initiating a reassignment, both he/she and the group's authorized or delegated official must sign section 4. If either of the two signatures is missing, the carrier may return the application per section 3.2 of this manual.
- If the person (or group) is terminating a reassignment, either party may sign section 4; both signatures are not required. If no signatures are present, the carrier may return the application per section 3.2 of this manual.
- *A CMS 855R is required to terminate a reassignment. The termination cannot be done via the CMS 855I.*

- The authorized or delegated official who signs section 4 must be someone who is currently on file with the carrier as such. If this is a new enrollment, with a joint submission of the CMS-855B, CMS-855I, and CMS-855R, the person must be listed on the CMS-855B as an authorized or delegated official. However, a comparison of signatures is not required.

- The effective date of a reassignment is the date the individual began or will begin rendering services with the reassignee.

- The carrier need not verify whether the reassigning individual is a W-2 employee or a 1099 contractor.

- There may be situations where a CMS-855R is submitted and the group practice is already enrolled in Medicare. However, the authorized official is not on file. In this case, the carrier shall return the CMS-855R, with a request that the group submit a CMS-855B change request adding the new authorized official.

- *In situations where the supplier is both adding and terminating a reassignment, each transaction must be reported on a separate CMS 855R. The same CMS 855R cannot be used for both transactions.*

- *In situations where an individual is reassigning benefits to a person/entity, both the reassignor and the reassignee must be enrolled with the same carrier.*

4.21 – National Provider Identifier (NPI)

(Rev. 173; Issued: 11-13-06; Effective/Implementation Dates: 11-15-06)

A. Submission of NPI

Every provider that submits an enrollment application must: (1) furnish its NPI in the applicable section of the CMS-855, and (2) submit a copy of the NPI notification it received from the National Plan and Provider Enumeration System (NPPES). (If the provider obtained its NPI via the Electronic File Interchange (EFI) mechanism, the provider shall submit a copy of the notification it received from its EFI Organization *(EFIO).* Typically, the notice will be in the form of a letter or e-mail. In the latter case, a printout of the e-mail is fine.))

If the contractor detects during the pre-screening phase that any of this information is missing, it shall follow the steps in section 3.1 of this manual.

The aforementioned policy applies to all applications listed in sections 2.1 and 2.2 of this manual. (The only exceptions to this involve voluntary terminations, deactivations, deceased providers, and CHOW applications submitted by the old owner. NPIs are not required in these instances.) Thus, for example, if a provider submits a change of information, it must furnish its NPI on the CMS-855, as well as a copy of its NPI notification from NPPES. If a reassignment package (as described in section 5.4 of this manual) is implicated, the NPIs and NPPES notices for all involved individuals and entities must be furnished; *even if an individual is reassigning benefits to an enrolled group, the group's NPI must be furnished on the CMS-855R and its NPI notification must be submitted. In short – and with the exceptions cited earlier in this paragraph – every CMS-855 submitted to Medicare must contain all NPIs requested on the form as well the associated NPI notifications.*

If the provider fails to submit the mandatory NPI data, the contractor shall follow the instructions in section 3.1 of this manual.

The NPI notifications shall be furnished regardless of whether the provider previously submitted such a notice to Medicare. Thus, if a provider furnished its NPI notice with a change request on March 1 and submits another change request on August 1, the NPI notice must accompany the August 1 change request.

B. Additional NPI Information

Contractors shall also abide by the following:

- *If a provider submits an NPI notice to the contractor as a stand-alone document (i.e., no CMS 855 was submitted), the contractor shall not create an L & T record*

in PECOS for the purpose of entering the NPI. The contractor shall simply place the notice in the provider file. Contractors shall only enter NPI data into PECOS that is submitted in conjunction with a CMS 855 (e.g., initial, change request). Thus, if a provider submits a CMS 855 change of information that only reports the provider's new NPI – and is accompanied by the appropriate NPI notification – the contractor may treat this as a change request and enter the data into PECOS.

- *There may be instances where the name on the NPI notification and/or EFIO notification does not exactly match the name on the CMS 855. The contractor shall take steps to resolve the discrepancy.*

C. Subparts - General

The contractor shall review and become familiar with the principles outlined in the "Medicare Expectations Subpart Paper," the text of which follows below

CMS encourages all providers to obtain NPIs in a manner similar to how they receive OSCAR numbers (i.e., a "one-to-one relationship"). For instance, suppose a home health agency is enrolling in Medicare. It has a branch as a practice location. The main provider and the branch will typically receive separate (albeit very similar) OSCAR numbers. It would be advisable for the provider to obtain an NPI for the main provider and another one for the branch – that is, one NPI for each OSCAR number.

Further instructions on how contractors shall deal with NPI-related matters will be issued in the near future.

D. Medicare Subparts Paper - Text

MEDICARE EXPECTATIONS ON DETERMINATION OF SUBPARTS BY MEDICARE ORGANIZATION HEALTH CARE PROVIDERS WHO ARE COVERED ENTITIES UNDER HIPAA

January 2006

Purpose of this Paper

Medicare assigns unique identification numbers to its enrolled health care providers that are used to identify the enrolled health care providers in the HIPAA standard transactions that they conduct with Medicare (such as electronic claims, remittance advices, eligibility inquiries/responses, claim status inquiries/responses, and coordination of benefits) and in cost reports and other non-standard transactions.

This paper is a reference for Medicare carriers and fiscal intermediaries (FIs). It reflects the Medicare program's expectations on how its enrolled organization health care providers who are covered entities under HIPAA1 will determine subparts and obtain NPIs for themselves and any subparts. These expectations may change over time to correspond with any changes in Medicare statutes, regulations, or policies that affect Medicare provider enrollment.

These expectations are based on the NPI Final Rule, on statutory and regulatory requirements with which Medicare must comply, and on policies that are documented in Medicare operating manuals but have not yet been codified. These Medicare statutes, regulations and policies pertain to conditions for provider participation in Medicare, enrollment of health care providers in Medicare and assignment of identification numbers for billing and other purposes, submission of cost reports, calculation of payment amounts, and the reimbursement to enrolled providers for services furnished to Medicare beneficiaries.

This paper categorizes Medicare's enrolled organization health care providers as follows:

- Certified providers and suppliers
- Supplier groups and supplier organizations
- Suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS)

This paper is not intended to serve as official HHS guidance to the industry in determining subparts for any covered health care providers other than those who are organizations and are enrolled in the Medicare program. This paper does not address health care providers who are enrolled in Medicare as individual practitioners. These practitioners are Individuals (such as physicians, physician assistants, nurse practitioners, and others, including health care providers who are sole proprietors). In terms of NPI assignment, an Individual is an Entity Type 1 (Individual) and is eligible for a single NPI. As Individuals, these health care providers cannot be subparts and cannot designate subparts. A sole proprietorship is a form of business in which one person owns all of the assets of the business and the sole proprietor is solely liable for all of the debts of the business. There is no difference between a sole proprietor and a sole proprietorship. In terms of NPI assignment, a sole proprietor/sole proprietorship is an Entity Type 1 (Individual) and is eligible for a single NPI. As an Individual, a sole proprietor/sole proprietorship cannot have subparts and cannot designate subparts.

Discussion of Subparts in the NPI Final Rule and its Applicability to Enrolled Medicare Organization Health Care Providers

1 Covered entities under HIPAA are health plans, health care clearinghouses, and those health care providers who transmit any health information in electronic form in connection with a health transaction for which the Secretary of HHS has adopted a standard (referred to in this paper as HIPAA standard transactions). Most Medicare Organization health care providers send electronic claims to Medicare (they are HIPAA standard transactions), making them covered health care providers (covered entities).

The NPI Final Rule adopted the National Provider Identifier (NPI) as the standard unique health identifier for health care providers for use in HIPAA standard transactions. On or before May 23, 2007, all HIPAA covered entities (except small health plans), to include enrolled Medicare providers and suppliers that are covered entities, must obtain NPIs and must use their NPIs to identify themselves as "health care providers" in the HIPAA standard transactions that they conduct with Medicare and other covered entities. Covered organization health care providers are responsible for determining if they have "subparts" that need to have NPIs. If such subparts exist, the covered organization health care provider must ensure that the subparts obtain their own unique NPIs, or they must obtain them for them.

The NPI Final Rule contains guidance for covered organization health care providers in determining subparts. Subpart determination is necessary to ensure that entities within a covered organization health care provider that need to be uniquely identified in HIPAA standard transactions obtain NPIs for that purpose.

The following statements apply to **all** entities that could be considered subparts:

- A subpart is not itself a separate legal entity, but is a part of a covered organization health care provider that is a legal entity. (All covered entities under HIPAA are legal entities.)

- A subpart furnishes health care as defined at 45 CFR 160.103.

The following statements may relate to some or all of the entities that a Medicare covered organization health care provider could consider as subparts:

- A subpart may or may not be located at the same location as the covered organization health care provider of which it is a part.

- A subpart may or may not have a Taxonomy (Medicare specialty) that is the same as the covered organization health care provider of which it is a part.

- Federal statutes or regulations pertaining to requirements for the unique identification of enrolled Medicare providers may relate to entities that could be considered subparts according to the discussion in the NPI Final Rule. Medicare covered organization health care providers must take any such statutes or regulations into account to ensure that, if Medicare providers are uniquely identified now by using Medicare identifiers in HIPAA standard transactions, they obtain NPIs in order to ensure they can continue to be uniquely identified. Medicare is transitioning from the provider identifiers it currently uses in HIPAA standard transactions (for organizations, these could be OSCAR Numbers, PINs, or NSC Numbers—known as legacy identifiers or legacy numbers) to NPIs. This makes it necessary that Medicare organization health care providers obtain NPIs

because the NPIs will replace the identifiers currently in use in standard transactions with Medicare and with all other health plans. In addition, Medicare organization health care providers must determine if they have subparts that need to be uniquely identified for Medicare purposes (for example, in HIPAA standard transactions conducted with Medicare). If that is the case, the subparts will need to have their own unique NPIs so that they can continue to be uniquely identified in those transactions.

- A subpart that conducts any of the HIPAA standard transactions separately from the covered organization health care provider of which it is a part must have its own unique NPI.

Enrolled Medicare organization health care providers who are covered entities under HIPAA must apply for NPIs as Organizations (Entity Type 2). Organization health care providers as discussed in this paper are corporations or partnerships or other types of businesses that are considered separate from an individual by the State in which they exist. Subparts of such organization health care providers who apply for NPIs are also Organizations (Entity Type 2).

Medicare Statutes, Regulations, Manuals

The Social Security Act (sections 1814, 1815, 1819, 1834, 1861, 1865, 1866, and 1891) and Federal regulations (including those at 42 CFR 400.202, 400.203, 403.720, 405.2100, 409.100, 410.2, 412.20, 416.1, 418.1, 424, 482.1, 482.60, 482.66, 483, 484, 485, 486, 489, 491, and 493.12) establish, among other things, the Conditions for Participation for Medicare providers and set requirements by which Medicare enrolls providers, requires cost reports, calculates reimbursement, and makes payments to its providers. These Medicare statutory and regulatory requirements are further clarified in various Medicare operating manuals, such as the State Operations Manual and the Program Integrity Manual, in which requirements and policies concerning the assignment of unique identification numbers, for billing and other purposes, are stated.

Medicare Organization Providers and Subparts: Certified Providers and Suppliers

Existing Medicare laws and regulations do not establish requirements concerning the assignment of unique identification numbers to Medicare certified providers and suppliers for billing purposes.

Certified Providers that bill Medicare fiscal intermediaries (hereinafter referred to as "providers"):

2 Clinical laboratory certification is handled by the Food and Drug Administration.

- Providers apply for Medicare enrollment by completing a CMS-855A.
- Most providers are surveyed and certified by the States3 prior to being approved as Medicare providers.
- Providers have in effect an agreement to participate in Medicare.4
- Providers include, but are not limited to: skilled nursing facilities, hospitals5, critical access hospitals, home health agencies, rehabilitation agencies (outpatient physical therapy, speech therapy), comprehensive outpatient rehabilitation facilities, hospices, community mental health centers, religious non-medical health care institutions.
- Providers are assigned OSCAR numbers to use to identify themselves in Medicare claims and other transactions, including cost reports for those providers that are required to file Medicare cost reports.
- In general, each entity that is surveyed and certified by a State is separately enrolled in Medicare and is considered a Medicare provider. (An exception involves home health agency branches. The branches are not separately enrolled Medicare providers.) In many cases, the enrolled provider is not itself a separate legal entity; i.e., it is an entity that is a part of an enrolled provider that is a legal entity and is, for purposes of the NPI Final Rule, considered to be a subpart.

Certified Suppliers, most of which bill Medicare carriers:

- Certified suppliers apply for Medicare enrollment by completing a CMS-855B.
- Certified suppliers include ambulatory surgical centers, portable x-ray suppliers, independent clinical labs (CLIA labs), rural health centers, and federally qualified health centers.
- Most certified suppliers bill the carriers; however, rural health centers and federally qualified health centers bill the fiscal intermediaries.
- Certified suppliers are typically surveyed and certified by the States prior to being approved for enrollment as Medicare certified suppliers. (For CLIA labs, each practice location at which lab tests are performed must obtain a separate CLIA Certificate for that location, though there are a few exceptions to this.)
- Certified suppliers may have in effect an agreement to participate in Medicare.
- Certified suppliers are assigned OSCAR numbers for purposes of identification within Medicare processes. However, the carriers assign unique identification numbers to certified suppliers for billing purposes. (For CLIA labs, a CLIA Number is typically assigned to each practice location for which a CLIA certificate is issued. A CLIA Number may not be used to identify a clinical laboratory as a "health care provider" in HIPAA standard transactions. The CLIA Number has no relation to the Medicare billing number.)

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3 Religious non-medical health care institutions are handled differently.

4 Community mental health centers attest to such an agreement. Religious non-medical health care institutions are handled differently.

5 Hospitals bill carriers for certain types of services.

- In many cases, the enrolled certified supplier is not itself a separate legal entity; i.e., it is an entity that is a part of an enrolled provider or certified supplier that is a legal entity and is, for purposes of the NPI Final Rule, considered to be a subpart.

In general, Medicare bases its enrollment of providers and certified suppliers on two main factors: (1) whether a separate State certification or survey is required, and (2) whether a separate provider or certified supplier agreement is needed. (The Taxpayer Identification Number, or TIN, is a consideration as well, though not to the degree of the two main factors.) The CMS regional offices generally make the final determinations on both of these factors; hence, Medicare provider and certified supplier enrollment policy is dictated to a significant degree by the CMS regional offices' decisions in particular cases.

Medicare Expectations for NPI Assignments for Providers and Certified Suppliers:
To help ensure that Medicare providers and certified suppliers do not experience denials of claims or delays in Medicare claims processing or reimbursement, **Medicare encourages each of its enrolled providers and certified suppliers to obtain its own unique NPI. These NPIs will eventually replace the legacy numbers that are used today in HIPAA standard transactions and in other transactions, such as cost reports.** In order for subpart determinations to mirror Medicare enrollment, each enrolled provider and certified supplier that is a covered organization health care provider would ensure the following:

- Obtain its own unique NPI.
- Determine if it has any subparts that are themselves enrolled Medicare providers. If there are subparts, ensure that they obtain their own unique NPIs, or obtain the NPIs for them. Example: An enrolled provider (a hospital) owns 10 home health agencies, all operating under the TIN of the hospital. Because the hospital and each of the 10 home health agencies is separately surveyed and enters into its own provider agreement with Medicare, a total of 11 unique NPIs should be obtained: one by the hospital, and one by each of the 10 home health agencies.

Regardless of how an enrolled provider or certified supplier that is a covered organization health care provider determines subparts (if any) and obtains NPIs (for itself or for any of its subparts, if they exist), Medicare payments, by law, may be made only to an enrolled provider or certified supplier.

Medicare Organization Providers and Subparts: Supplier Groups and Supplier Organizations

Existing Medicare laws and regulations do not establish requirements concerning the assignment of unique identification numbers to supplier groups and supplier organizations for billing purposes.

- Supplier groups and supplier organizations apply for Medicare enrollment by completing a CMS-855B.
- Supplier groups and supplier organizations bill Medicare Part B carriers.
- Supplier organizations are certified by the States, or certified by the Food and Drug Administration (FDA), or must undergo an on-site inspection by the carrier. These requirements vary by type of supplier organization.
- Supplier groups are primarily group practices, such as a group of physicians or other practitioners.
- Supplier organizations include ambulance companies, mammography facilities, and independent diagnostic testing facilities (IDTFs).

Medicare enrolls supplier groups/supplier organizations based on Taxpayer Identification Numbers (TINs); that is, although a supplier group or supplier organization may have multiple locations, if each location operates under the same single TIN, Medicare does not separately enroll each location. There are exceptions:

1. When there is more than one Medicare specialty code associated with a single TIN. For instance, if a physician group practice is also an IDTF, it has two different Medicare specialties. The supplier group (the physician group practice) must enroll as a group and the supplier organization (the IDTF) must enroll as a supplier organization. The group practice would complete a CMS-855B and the IDTF would complete a CMS-855B. Each one would receive its own unique Medicare billing number.

2. If a separate site visit, State certification, or on-site inspection by the carrier or if FDA certification is required for each practice location of that supplier group/supplier organization.

In those above exceptions, Medicare separately enrolls each different Medicare specialty and each separately visited, certified or carrier-inspected practice location.

Medicare Expectations for NPI Assignments for Supplier Groups and Supplier Organizations: To help ensure that Medicare supplier groups and supplier organizations do not experience delays in Medicare claims processing or reimbursement, **Medicare encourages each of its enrolled supplier groups and supplier organizations to obtain its own unique NPI. These NPIs will eventually replace the legacy numbers that are used today in HIPAA standard transactions and in other transactions, such as cost reports.** In order for subpart determinations to mirror Medicare enrollment, each enrolled supplier group and supplier organization that is a covered organization health care provider would ensure the following:

- Obtain its own unique NPI.
- Determine if it has any subparts that are themselves enrolled Medicare providers. If there are subparts, ensure that they obtain their own unique NPIs, or obtain the NPIs for them. Example: An enrolled IDTF has four different locations, and each one must be separately inspected by the carrier. All four locations operate

under a single TIN. Because each location is separately inspected in order to enroll in Medicare, a total of four unique NPIs should be obtained: one for each location.

Regardless of how an enrolled supplier group or supplier organization that is a covered organization health care provider determines subparts (if any) and obtains NPIs (for itself or for any of its subparts, if they exist), Medicare payments, by law, may be made only to an enrolled supplier group or supplier organization.

Medicare Organization Providers and Subparts: Suppliers of Durable Medical Equipment, Prosthetics, Orthotics, or Supplies (DMEPOS)

Medicare regulations require that each practice location of a supplier of DMEPOS (if it has more than one) must, by law, be separately enrolled in Medicare and have its own unique Medicare billing number.

- A supplier of DMEPOS enrolls in Medicare through the National Supplier Clearinghouse (NSC) by completing a CMS-855S.

- Suppliers of DMEPOS bill Durable Medical Equipment Regional Carriers (DMERCs).

- Suppliers of DMEPOS include but are not limited to pharmacies, oxygen suppliers, and outpatient physical therapy agencies. (Any organization that sells equipment or supplies that are billed to Medicare through the DMERCs must be enrolled as a Supplier of DMEPOS through the NSC. Sometimes, these are organizations who also furnish services that are covered by Medicare, such as ambulatory surgical centers. In order to be reimbursed for the DME supplies that they sell, they must separately enroll in Medicare as a Supplier of DME.)

Medicare Expectations for NPI Assignments for Suppliers of DMEPOS: Each enrolled supplier of DMEPOS that is a covered entity under HIPAA must designate each practice location (if it has more than one) as a subpart and ensure that each subpart obtains its own unique NPI.

Final Notes About NPIs

Enrolled organization health care providers or subparts who bill more than one Medicare contractor: An enrolled organization health care provider or subpart is expected to use a single (the same) NPI when billing more than one Medicare contractor. For example, a physician group practice billing a Maryland carrier and also billing a Pennsylvania carrier would use a single (the same) NPI to bill both carriers.

Enrolled organization health care providers or subparts who bill more than one type of Medicare contractor: Generally, the type of service being reported on a Medicare claim determines the type of Medicare contractor who processes the claim. Medicare will expect an enrolled organization health care provider or subpart to use a single (the same) NPI when billing more than one type (fiscal intermediary, carrier, RHHI, DMERC) of Medicare contractor. However, in certain situations, Medicare requires that the organization health care provider (or possibly even a subpart) enroll in Medicare as more than one type of provider. For example, an ambulatory surgical center enrolls in Medicare as a Certified Supplier and bills a carrier. If the ambulatory surgical center also sells durable medical equipment, it must also enroll in Medicare as a Supplier of DME and bill a DMERC. This ambulatory surgical center would obtain a single NPI and use it to bill the fiscal intermediary and the DMERC. Medicare expects that this ambulatory surgical center would report two different Taxonomies when it applies for its NPI: (1) that of Ambulatory Health Care Facility—Clinic/Center--Ambulatory Surgical (261QA1903X) and (2) that of Suppliers—Durable Medical Equipment & Medical Supplies (332B00000X) **or** the appropriate sub-specialization under the 332B00000X specialization.

Enrolled organization health care providers who determine subparts for reasons unrelated to Medicare statutes, regulations or policies:

Consistent with the NPI Final Rule, covered organization health care providers designate subparts for reasons that are not necessarily related to Medicare statutes or regulations. If a Medicare organization health care provider designates as subparts entities other than those who are enrolled Medicare providers, and those subparts obtain their own NPIs and use those NPIs to identify themselves in HIPAA standard transactions with Medicare, those NPIs will not identify enrolled Medicare providers. Medicare is not required to enroll them. (NPI Final Rule, page 3441: "If an organization health care provider consists of subparts that are identified with their own unique NPIs, a health plan may decide to enroll none, one, or a limited number of them (and to use only the NPIs of the one(s) it enrolls."))

Medicare will, of course, use NPIs to identify health care providers and subparts in HIPAA standard transactions. (NPI Final Rule, page 3469: section 162.412(a): "A health plan must use the NPI of any health care provider (or subpart(s), if applicable) that has been assigned an NPI to identify that health care provider on all standard transactions where that health care provider's identifier is required.") Medicare will ensure that the NPIs it receives in HIPAA standard transactions are valid6. Medicare will reject HIPAA standard transactions that contain invalid NPIs. Valid NPIs, however, like the provider identifiers used today, must be "known" to Medicare. Medicare is not permitted to make payments for services rendered by non-Medicare providers7, nor is it permitted to reimburse providers who are not enrolled in the Medicare program. Medicare will return,

6 The check-digit algorithm will determine the validity of an NPI. This is not the same as knowing the health care provider being identified by a particular NPI.

7 There may be exceptions for emergency or very unusual situations.

with appropriate messages, any HIPAA standard transactions containing valid but unrecognizable NPIs.

5.2 – Verification of Data

(Rev. 173; Issued: 11-13-06; Effective/Implementation Dates: 11-15-06)

The general purpose of the verification process is to determine if any of the data furnished on the CMS-855 conflicts with Qualifier.net, supporting documentation, or any other information. The contractor may begin the verification process at any time, including during the prescreening phase.

A. Concurrent Reviews

If the contractor receives multiple CMS-855s for related entities, it can perform concurrent reviews of similar data. For instance, suppose a chain home office submits initial CMS-855A applications for four of its chain providers. The ownership information (sections 5 and 6) and chain home office data (section 7) is the same for all four providers. The contractor need only verify the ownership and home office data once; it need not do it four times – once for each provider. However, the contractor shall document in each provider's file that a single verification check was made for all four files.

For purposes of this requirement: (1) there must be some sort of organizational, employment, or other business relationship between the entities, and (2) the applications have to have been submitted simultaneously – or at least within a few weeks of each other. As an illustration, assume that Group Practice A submits an initial CMS-855B on January 1. Group Practice B submits one on October 1. *Section 6* indicates that Joe Smith is a co-owner of both practices, though both entities have many other owners that are not similar. In this case, the contractor must verify Mr. Smith's data in both January and October. It cannot use the January verification and apply it to Group B's application because (1) the applications were submitted nine months apart, and (2) there is no evidence that the entities are related. (On the other hand, a CMS-855I, CMS-855B, and CMS-855R enrollment package would probably meet the two criteria above.)

B. Qualifier.net

Unless stated otherwise in this manual or in other CMS directives (e.g., JSMs), the contractor shall verify all data furnished on the CMS-855 using Qualifier.net. Such data includes, but is not limited to:

- Adverse legal history of the provider and all entities and persons listed in sections 5 and 6 of the CMS-855A.

- *For non-certified suppliers (e.g., physician clinics), all practice locations and phone numbers listed in section 4 of the CMS-855.*

- Legal business names and employer identification numbers of all entities listed in section 5 of the CMS-855. (Social security numbers and dates of birth are validated by PECOS – and reviewed against Qualifier.net for discrepancies – via the procedures outlined in section 4.2.1 of this manual.)

- Billing agency information (e.g., legal business name) listed in section 8 of the CMS-855.

- HHA staffing agencies (e.g., legal business name) listed in section 12 of the CMS-855A.

If there is a discrepancy between the information furnished by the applicant and the information on Qualifier.net, the contractor shall use alternative means to confirm the data in question. Examples of such other means include, but are not limited to:

- **Phone number of provider's practice location or billing agency -** Call the number listed on the application directly; check the Yellow Pages.

- **Provider's practice location -** Check the Yellow Pages; conduct a site visit.

- **Provider's "doing business as" name -** Review the IRS CP-575, articles of incorporation, State Web site, etc.

- **Legal business name or tax identification number of an entity listed in section 5 or 6 of the CMS-855** – Ask for a copy of the entity's CP-575.

If the discrepancy still cannot be resolved, the contractor shall request clarifying information from the provider to help resolve the unverifiable information.

Any information on the CMS-855 that is verified via supporting documentation (e.g., certifications, licenses) need not also be verified through Qualifier.net. For instance, suppose a nurse practitioner furnishes her licensure information in section 2 of the CMS-855I and includes a copy of the license as supporting documentation. The carrier need not verify the licensure data against Qualifier.net, as it has already been verified via the documentation. Other examples of data verifiable via documentation include:

- National Provider Identifier (NPI)

- Organization type listed in section 2 of the CMS-855 (e.g., corporation, limited liability company, non-profit status)

- Legal business name and tax identification number of the provider (e.g., IRS CP-575)

- Education listed in section 2 of the CMS-855I

In short, all information furnished on the CMS-855 must be verified via Qualifier.net, unless it is data: (1) exempted from this requirement in this manual or other CMS directive, or (2) that is verifiable via documentation submitted by the provider.

In addition:

- The contractor shall develop procedures to identify situations and patterns on Qualifier.net that might indicate fraudulent or abusive practices.

- All Qualifier.net executive summaries are valid for 120 days.

- Contractors are not required to run additional Qualifier.net searches on "AKA" names that appear on Qualifier.net.

- There may be instances where CMS directs contractors to verify certain data via the Medicare Exclusion Database and/or the GSA Excluded Parties List System, rather than through Qualifier.net. If a potential hit is found on the GSA List and the contractor needs to make a positive identity, it shall contact the agency that took the action for further information; based on this data, the contractor shall determine whether it is the same person. If a positive match still cannot be made, the contractor may approve the application.

- Contractors are not required to use the Fraud Investigation Database (FID) when processing incoming enrollment applications, including changes of information. If the contractor chooses to use the FID on a particular provider, owner, etc., and the person/entity appears on the FID, the contractor should continue to process the application. However, it should refer the matter to the PSC for guidance.

- In some instances, a contractor may need to contact another Medicare contractor for information regarding the provider. The latter contractor shall respond to the former contractor's request within three *business* days absent extenuating circumstances. (If the information in question involves changes to an existing PECOS record, the contractors shall follow the procedures outlined in section 15 of this manual.)

5.3 – Requesting and Receiving Clarifying Information

(Rev. 173; Issued: 11-13-06; Effective/Implementation Dates: 11-15-06)

A. Requesting Clarifying Data

After the completion of the 15-day pre-screening phase, if the contractor determines that it needs clarifying information from the provider, the contractor shall send a letter to the provider – preferably via e-mail or fax - that contains, at a minimum, the elements listed below:

1. A list of all data to be clarified;

2. A request that the provider submit the clarifying data within a contractor-specified timeframe (i.e., the contractor can use whatever timeframe it wants, so long as it is within reason);

3. The phone number and name of a contact person at the contractor site;

4. The CMS Web site at which the CMS-855 forms can be found. The contractor shall instruct the provider to print out the page(s) containing the data in question; enter the data on the blank page; sign and date a new, blank certification statement; and send it to the contractor. (As an alternative, the contractor can fax the blank page(s) and certification statement to the provider.) The provider need not furnish its initials next to the data element(s) in question.

5. A fax number and mailing address to which the data or documentation can be sent.

(The contractor can forgo items 4 and 5 above if resolution of the issue will not involve changes to the CMS-855.)

If the provider fails to furnish <u>all</u> of the requested clarifications within 60 calendar days after the contractor's request, the contractor shall reject the application. It shall notify the provider via letter or e-mail that the application is being rejected, the reason(s) for the rejection, and how to reapply. The contractor is free to keep the original application on file after rejection. If the provider requests a copy of its application, the contractor may fax it to the provider.

In addition:

- **Only One Request Needed** - The "clarification letter" is the only request for clarification that the contractor must make. Obviously, the contractor should respond to any of the provider's telephone calls, e-mails, etc., resulting from the

clarification letter. However, the contractor need not – on its own volition – make an additional request for clarification.

To the maximum extent possible, the contractor should avoid contacting a provider for clarifying information until it has attempted to verify all data on the application. This will prevent the contractor from contacting the provider each time it discovers a discrepancy.

- **Resubmission after Rejection** – If the provider's application is rejected, the provider must complete and submit a new CMS-855 and all supporting documentation.

- **Appeals** – The provider may not appeal a rejection of its enrollment application.

- **Policy Application –** Unless stated otherwise in this manual, the policies enunciated in this section 5.3 apply to all CMS-855 applications identified in sections 2.1 and 2.2 above (e.g., changes of information, reassignments).

- **Good-Faith Effort by Provider** – If the provider fails to submit the requested clarification within the aforementioned 60-day timeframe but appears to be making a good-faith effort to do so, the contractor may at its discretion continue processing the application

- **Incomplete Responses** – The provider must furnish <u>all</u> clarifying data requested by the contractor within the applicable timeframe. Whether the provider indeed furnished all the information is a decision resting solely with the contractor.

  Moreover, if the provider furnishes some, but not all, of the requested data within the 60-day period, the contractor is not required to contact the provider again to request the rest of the information. The contractor has the discretion to wait until the expiration of the 60-day period and then reject the application; however, as stated above, it should take into account any good faith efforts made by the provider to furnish the information.

- **Rejections vs. Denials** – *There may be instances where the provider failed to fully comply with the contractor's request for additional or clarifying information.* (A common example would be SSNs and EINs*, or the provider's refusal to submit the requested data.*) There are two possible outcomes:

  - Rejection of the application under 42 CFR § 424.525(a), due to the provider's failure to furnish clarification within 60 days of the request, or

  - Denial of the application *if one of the denial reasons in section 6.2 of this manual is implicated.*

If the contractor is faced with this situation, it shall contact its DPSE contractor liaison for guidance prior to making its decision to reject or deny.

- **Commencement of Timeframe** – The 60-day clock described above commences when the contractor mails, faxes, or e-mails the letter.

B. Relationship to the Pre-Screening Process

The contractor is free to begin the verification process during the pre-screening phase described in section 3.1 of this manual. If the contractor, in doing so, uncovers data requiring further development (e.g., problems verifying the SSN of a managing employee; Qualifier.net indicates that a person may be using two SSNs), the contractor may include this request for clarifying information within the pre-screening letter. This, in turn, means that the provider must furnish: (1) all data and documentation requested in the pre-screening letter within 60 calendar days of the request, and (2) all clarifications asked for in the contractor's request for clarifying information within 60 calendar days of the request.

EXAMPLE 1: The provider submits a CMS-855B on March 1. The contractor pre-screens the application and finds that all data elements have been completed and all required documentation submitted. Hence, no pre-screening letter is needed. Since several SSN discrepancies were found during the validation process, however, the contractor sent a request for clarifying information to the provider on March 20. In this scenario, the provider must furnish all of the requested data/clarifications by May 19.

EXAMPLE 2: The provider submits a CMS-855B on March 1. The contractor completed its pre-screening of the application on March 7 and found that three relatively minor data elements were missing, thus triggering the need for a pre-screening letter to be sent no later than March 16. The contractor decides to begin the verification process on March 8 and completes validation on March 13, though it found two SSN discrepancies. The contractor thus sends out a single letter on March 14 addressing both the missing data elements (pre-screening) and the SSN issues (request for clarifying information). In this situation, the provider must furnish both the missing data elements and the requested clarification by May 13.

Now suppose that the contractor had not completed the entire verification process by March 16. In its pre-screening letter, the contractor mentioned two SSN discrepancies it uncovered in the verification process thus far. The contractor completed the validation process on April 2; that same day, the contractor sent a request for additional information to the provider regarding two EIN discrepancies. Here, the provider must furnish the missing information and SSN clarifications by May 13. Even if it does so, it must still provide the EIN clarifications by June 1 (or 60 days after the April 2 letter was sent). If the provider fails to comply with the March 14 letter, it may reject the application on May 13 without waiting to see if the provider can furnish the requested EIN clarifications.

C. Receiving Clarifying Information

Unless stated otherwise in this manual, any data collected on the CMS-855 for which the contractor requested clarification must be furnished by the provider on the applicable page(s) of the CMS-855. A newly-signed and dated certification statement must also be submitted. Note that this certification statement must be separate and distinct from the previous certification statement; that is, the provider cannot simply add its signature to the existing statement. It must sign a separate one.

The contractor can receive the clarifying information, including the new certification statement, via fax. Upon receipt, the contractor shall verify the new data. (The contractor need not re-verify the existing data on the application.)

D. Unsolicited Submission of Clarifying Information

Any new or changed information submitted by an applicant prior to the date the contractor finishes processing the application is considered to be an update to the original application. (It is immaterial whether the data was requested by the contractor.) The data 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 on its own volition 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 59^{th} 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.

E. Site Visits

In addition to the site visits required for all IDTF, DME and CMHC applicants (which have their own site visit instructions), the contractor may conduct site visits for other applicants seeking enrollment in the Medicare program or to verify the status of currently enrolled providers. Such site visits should be unannounced; the contractor representatives shall always conduct themselves in a professional manner, disclosing to the provider appropriate identifying credentials and explaining the purpose of the visit. The contractor shall maintain records of all site visits to support decisions regarding the denial or revocation of a Medicare billing number.

5.5 – Special Verification Procedures for CMS-855A Applications

(Rev. 173; Issued: 11-13-06; Effective/Implementation Dates: 11-15-06)

Unless otherwise stated, all references to the "RO" in this section 5.5 refer to the RO's survey & certification staff, not its provider enrollment personnel.

A. Audit and Claims Intermediaries

For purposes of enrollment, there are generally two categories of intermediaries: audit intermediaries and claims intermediaries. The audit intermediary enrolls the provider, conducts audits, etc. The claims intermediary pays the provider's claims. In most cases, the provider's audit intermediary and claims intermediary will be the same; on occasion, they will be different. (This often happens with provider-based entities, where the provider's enrollment application will be processed by the parent provider's intermediary (audit intermediary) and its claims will be paid by a different intermediary (claims intermediary)).

When enrolling a home health agency (HHA), hospice, rural health clinic (RHC), or federally qualified health center (FQHC), the following rules apply:

- HHAs & Hospices – If the entity is provider-based, it shall submit its enrollment application to the parent provider's intermediary. If the entity is freestanding, the application should go to the applicable regional home health intermediary (RHHI). Regardless of whether the entity is provider-based or not, however, the claims intermediary will be the RHHI unless CMS directs otherwise.

- RHCs – If the entity is provider-based, it should submit its enrollment application to the parent provider's intermediary. If the entity is freestanding, the application should go to the applicable regional RHC intermediary.

- FQHC – All FQHC applications, whether provider-based or freestanding, shall be processed by United Government Services.

Thus, the audit and claims intermediaries will typically be different if the enrollee is a provider-based HHA, hospice, or RHC. In these situations, the audit intermediary (i.e., the parent provider's intermediary) shall process all changes of information, including all EFT changes. The audit intermediary shall notify the applicant during the initial enrollment process that all future changes of information must be sent to the audit intermediary, not the claims intermediary. (Quite often, a provider will submit an EFT change request to the claims intermediary because the latter processes the provider's claims.) If the provider inadvertently sends a change of information request (or, for that matter, an initial enrollment) to the claims intermediary, the latter shall return the application per section 3.2 of this manual.

Once the audit intermediary finishes processing the initial enrollment application, it shall fax a copy of the application to the claims intermediary. It shall also fax copies of any future changes of information involving payment issues (e.g., EFT) to the claims intermediary once processing is complete.

It is imperative that the audit and claims intermediaries effectively communicate and coordinate with each other in all payment-related matters involving the provider. This includes, among other things, notifying the other intermediary whenever a tie-in or tie-out notice is received, informing the other intermediary about program integrity issues, etc.

B. Provider Nomination

As of October 1, 2005, freestanding providers entering the Medicare program may no longer express a preference for a particular fiscal intermediary. The ROs will assign these new providers to the local Blue Cross plan that serves the State or U.S. territory in which the provider is located. The term "new provider" includes situations where a change of ownership occurs but the new owner does not accept assignment of the existing provider agreement; in this situation, the provider will be assigned to the local Blue Cross plan.

There are several exceptions to this policy:

- Freestanding specialty providers, such as (but not limited to) HHAs and hospices, will continue to be assigned to their designated specialty intermediaries;

- Provider-based facilities will continue to be assigned to the audit intermediary that serves the parent provider, even if it is not the local Blue Cross plan.

- New providers that belong to or are joining CMS-recognized chains have the option to be assigned to the local Blue Cross plan or to the intermediary that services the chain home office;

- Providers involved in CHOWs where the new owner <u>accepts</u> assignment of the existing provider agreement will remain with their current intermediary, even if it is not the local Blue Cross plan.

In all cases, the ROs retain jurisdiction over the assignment and reassignment of providers to their respective intermediaries. If an intermediary receives a request from a provider to change its existing intermediary, it shall refer the provider to the RO contact person who handles intermediary assignments.

C. Changes of Ownership (CHOWs)

1. CHOW Definitions

Changes of ownership (CHOWs) are officially defined and governed by 42 CFR § 489.18 and § 3210 of the CMS State Operations Manual (SOM). The ROs make the final determination as to whether a CHOW has occurred, unless this function has been delegated.

For purposes of provider enrollment only, there are three main categories of CHOWs captured on the CMS-855A application:

- **"Standard" CHOW –** This occurs when the OSCAR number and provider agreement of a provider are transferred to another entity as a result of that entity's purchase of the provider. To illustrate, suppose Entity A is enrolled in Medicare, but Entity B is not. B acquires A. In this case, A's provider agreement and OSCAR number transfer to B.

  This is perhaps the most frequently encountered change of ownership scenario. Even though it is technically an acquisition (i.e., B bought/acquired A) under § 489.18, this situation falls under the "CHOW" category – as opposed to the "Acquisition/Merger" category – on the CMS-855A.

- **Acquisition/Merger** - In general, this occurs when two or more Medicare-enrolled entities combine, leaving only one remaining OSCAR number and provider agreement. For instance, Entity A and Entity B are both enrolled in Medicare. Each entity has its own OSCAR number and provider agreement. The two entities decide to merge. Since Entity B's OSCAR number and provider agreement will be eliminated (leaving only Entity A's OSCAR number and provider agreement), a § 489.18 merger has occurred.

  If the acquisition results in an existing provider having new owners but keeping its same provider number, the applicant should check the CHOW block.

- **Consolidations** - This occurs when two or more entities combine, creating a brand new entity. To illustrate, suppose Entities A and B (both of which are enrolled in Medicare) decide to combine and, in the process, create a new entity – Entity C. The OSCAR numbers and provider agreements of both A and B are eliminated. Entity C will have its own OSCAR number and provider agreement.

  Note the difference between acquisitions/mergers and consolidations. In an acquisition/merger, when A and B combine there is one surviving entity. In a consolidation, however, when A and B combine there are no surviving entities. Rather, a new entity is created – Entity C.

Unless specified otherwise, the term "CHOW" as used below includes CHOWs, acquisitions/mergers and consolidations.

2. Determining Whether a CHOW Has Occurred

In examining whether: (1) a CHOW has occurred, and/or (2) the new owner will be accepting assignment of the Medicare assets and liabilities of the old owner, the intermediary shall perform all necessary research – including reviewing the sales agreement, contacting the provider(s) to request clarification of the sales agreement, etc. – before referring the matter to the RO for guidance. Such referrals to the RO should only be made if the intermediary is truly unsure as to whether a CHOW has taken place and should not be referred as a matter of course. (A RO CHOW determination is typically not required prior to the intermediary making its recommendation.) Note that a provider may undergo financial and administrative changes that it may consider to be a CHOW, but does not meet the definition shown in 42 CFR § 489.18.

While a CHOW is usually accompanied by a change in the tax identification number (TIN), this is not always the case. There may be a few instances where the TIN will remain the same. Conversely, there may be some cases where a provider is changing its TIN but not its ownership. In short, while a change of TIN (or lack thereof) is evidence that a CHOW has or has not occurred, it is not the most important factor; rather, the change in the provider's ownership arrangement is. Hence, it is imperative that the intermediary review the sales agreement closely, as this will give the best indication as to whether a CHOW has occurred.

If the provider claims that the transaction in question is a stock transfer and not a CHOW, the intermediary reserves the right to request any information from the provider to verify this *(e.g., copy of the stock transfer agreement).*

3. Processing CHOW Applications

The intermediary shall process CHOW applications in accordance with the following:

- Unless otherwise specified in this section, both the old and new owners must submit separate CMS-855A applications as well as copies of the interim and final sales agreements.

- Old owner – The old owner's CMS-855A CHOW application does not require a recommendation for approval or denial; any recommendations will be based upon the CHOW application received from the new owner. Also, the creation of an enrollment record in PECOS for the old owner is not required, though an L & T record is.

If a certification statement is not on file for the old owner, the intermediary shall request that section 6 be completed for the individual who is signing the certification statement. The intermediary shall review this individual against all applicable databases, including Qualifier.net.

If a CMS-855A is not received from the new owner within 14 calendar days of receipt of the old owner's CMS-855A, the intermediary shall contact the new owner. If the new owner fails to: (1) submit a CMS-855A and (2) indicate that it accepts assignment of the provider agreement, within 30 calendar days after the intermediary contacted it, the latter shall stop payments unless the sale has not yet taken place per the terms of the sales agreement. Payments to the provider can resume once this information is received and the intermediary ascertains that the provider accepts assignment.

- New owner – The intermediary shall ensure that the information contained in the sales agreement is consistent with that reported on the new owner's CMS-855A. The intermediary shall not forward a copy of the application to the State agency until it has received and reviewed the final sales agreement. It need not revalidate the information on the CMS-855A even if the data may be somewhat outdated by the time the final sales agreement is received.

  If the old owner's CMS-855A is available at the time of review, the intermediary shall examine the information thereon against the new owner's CMS-855A to ensure consistency (e.g., same names). If the old owner's CMS-855A has not been received, the intermediary shall contact the old owner and request it. However, the intermediary may begin processing the new owner's application without waiting for the arrival of the old owner's application; it may also make its recommendation to the State agency without having received the old owner's CMS-855A. The intermediary shall not make a recommendation for approval unless the new owner has checked on the form that it will assume the provider agreement and that the terms of the sales agreement indicate as such.

  The intermediary shall determine whether the terms of the contract indicate that the new owner will assume the provider agreement. In many cases, the sales agreement will not specifically refer to the Medicare agreement. Clearly, if the box in section 2F is checked "yes" and the sales agreement either: (1) confirms that the new owner will assume the agreement or (2) is relatively silent on the matter, the intermediary can proceed as normal. (The RO will obviously make the final decision.) Conversely, if the agreement indicates that the assets and liabilities will not be accepted, the contractor should recommend denial. As discussed previously, such matters can be referred to the RO if needed.

- To the maximum extent practicable, CMS-855A applications from the old and new owners in a CHOW should be processed as they come in. The intermediary should not wait for applications from both the old and new owner to arrive before processing them. However, unless the instructions in this manual indicate

otherwise, the intermediary should attempt to send the old and new applications to the State simultaneously, rather than as soon as they are processed. For instance, suppose the old owner submits an application on March 1. The intermediary should begin processing the application immediately, without waiting for the arrival of the new owner's application. Yet it should avoid sending the old owner's application to the State until the new owner's application comes in. (For acquisition/mergers and consolidations, the intermediary may send in the applications separately, since one number is going away.)

- All subunits that have a separate provider agreement (e.g., HHA subunits) must submit their CHOW on a separate CMS-855A. They cannot report the CHOW via the main provider's CMS-855A.

  If the subunit has a separate OSCAR identifier but not a separate provider agreement (e.g., hospital psychiatric unit, HHA branch), the CHOW can be reported on the main provider's CMS-855A. This is because the subunit is a practice location of the main provider and not a separately enrolled entity.

- CMS-855A CHOW applications may be accepted by the intermediary up to 90 calendar days prior to the anticipated date of the proposed ownership change. Any application received more than three months in advance of the projected sale date can be returned under section 3.2 of this manual.

- If a final sales agreement is not submitted within 90 days after the intermediary's receipt of the new owner's application, the intermediary shall reject the application Though the intermediary must wait until the 90th day to return the application, the intermediary may do so regardless of how many times it contacted the new owner or what type of responses (short of the actual receipt of the sales agreement) were obtained.

  With respect to HHA capitalization, the intermediary need not wait 90 days to return the application, but should give the HHA a <u>reasonable</u> period of time (as defined by the intermediary) to furnish the necessary documentation.

- If the intermediary ascertains by any means that an enrolled provider has: (1) been purchased by another entity or (2) purchased another Medicare enrolled provider, the intermediary shall immediately request CMS-855A applications from both the old and new owners. If the new owner fails to submit the CMS-855A provider within the latter of: (1) the date of acquisition or (2) thirty (30) days after the request, the intermediary shall stop payments to the provider. Payments may be resumed upon receipt of the completed CMS-855A.

- Medicare payments shall continue to be made to the old owners until the CHOW is approved by the RO, even if the old owner submits a CMS 588 to change the bank account to that of the new owner.

- Unlike the new owner in a CHOW or consolidation, the new owner in an acquisition/merger need not complete the entire CMS-855A. This is because the new owner is already enrolled in Medicare; as such, the provider being acquired would simply be reported as a practice location in section 4 of the new owner's CMS-855A.

- There may be instances where the parties in a CHOW, acquisition/merger or consolidation transaction may not have signed a "sales agreement" or "bill of sale" in the conventional sense of the term. (This may often occur with consolidations.) The intermediary may, but is not required to, accept alternative documentation, so long as such documentation furnishes clear verification of the terms of the transaction as well as all information necessary to carry out all applicable instructions pertaining to changes of ownership.

- When reviewing the sales agreement, the intermediary shall primarily look for: (1) consistency with the data furnished on the CMS-855A (e.g., same names), and (2) confirmation that the transaction qualifies as a CHOW.

- On occasion, a CHOW may be occurring in conjunction with a change to the facility's provider sub-type. This most frequently happens when a hospital undergoes a CHOW and is changing from a general hospital to another type of hospital, such as a psychiatric hospital. Although a change in hospital type is considered a change of information, it is not necessary for the provider to submit separate applications – one for the COI and one for the CHOW. Instead, all information (including the change of hospital type) should be reported on the CHOW application; the entire application should then be processed as a CHOW. However, if the facility is changing from one main provider type to another (e.g., hospital converting to a SNF) and also undergoing a CHOW, the provider must submit its application as an initial enrollment.

- Unless stated otherwise in this manual, the intermediary shall ensure that all applicable sections of the CMS-855A for both the old and new owners are completed in accordance with the instructions on the CMS-855A.

4. <u>Special PECOS Policies Regarding CHOWs</u>

- If a provider lists a practice location that has a different OSCAR number from the main facility (e.g., HHA branch, hospital unit, OPT extension site), the intermediary shall create a separate enrollment record in PECOS for that location (i.e., the main facility and the practice location will each have its own enrollment record). *Thus, if a hospital had an OSCAR number of 00-0000 and its rehab unit was numbered 00-T000 (alpha code "U"), a separate enrollment record must be created for the hospital unit.*

- The intermediary is not required to create an enrollment record in PECOS for the old owner.

- The intermediary is not required to create a new L & T record in PECOS when the tie-in notice comes in, as the existing record should not be in final status and can be changed. Simply changing the L & T status is sufficient.

- Suppose a request for a CHOW comes in and the intermediary enters the data into PECOS as a CHOW. It turns out, after additional research, that the transaction was not a CHOW (e.g., was a stock transfer; was an initial enrollment because the new owner refused to accept the Medicare liabilities). If the intermediary cannot change the transaction type in PECOS., it can leave the record in CHOW status but should note the provider's file that the transaction was not a CHOW.

D. Additional Processing Instructions

- ***Multiple Providers Under a Single TIN*** - It is acceptable for multiple providers to have the same TIN. However, each provider must submit a separate CMS-855 application, and the intermediary must create a separate enrollment record for each.

- ***Non-Enrollment Functions and Timeliness*** – *There may be instances where a fiscal intermediary cannot forward an application to the State until it performs certain non-enrollment functions pertaining to that application (e.g., the reimbursement unit needs to examine patient listing data). The intermediary can flip the PECOS status to "approval recommended" prior to the completion of this non-enrollment activity, but only if this is the lone remaining activity to be completed. In other words, all enrollment activities required to be performed under Chapter 10 must have been completed prior to the intermediary making its determination.*

- ***Recommendation Letters –*** *It is suggested that the contractor include in its recommendation letter any extraneous information or circumstances that, in its judgment, might be of interest or importance to the State or RO. For instance, suppose the FI, while entering data in PECOS, discovers that the provider is enrolled in two other intermediary jurisdictions as a different provider type. This is information that the RO may wish to have.*

- ***Tie-in Notices*** – *When the contractor receives a tie-in notice or approval letter from the RO, it shall review its contents to ensure that the data on the notice/letter matches that on the CMS-855. If there are discrepancies (e.g., different legal business name, address), the contractor shall notify its DPSE liaison. It shall also contact the applicable RO's survey and certification unit to determine why the data is different.*

5.7 – Special Procedures for Processing *Complete* CMS-855 Applications Submitted by Enrolled Providers

(Rev. 173; Issued: 11-13-06; Effective/Implementation Dates: 11-15-06)

In situations where an enrolled provider submits a *complete* CMS-855 application: (1) voluntarily, (2) *as part of any change request if the provider is not in PECOS,* or (3) as part of a reactivation, the following rules apply:

- The contractor shall verify all data elements on the application in accordance with section 5.2 of this manual, just as it would with an initial enrollment application. With EFT changes, all of the data on the full application must be verified in order for the change to be approved.

- The applications are treated as initial applications for timeliness purposes (e.g., 80% within 60 days)). They should also be entered into PECOS as initial applications; the L & T status can be changed to "approved" once all of the data has been verified.

- If the enrollee is a certified supplier or certified provider, the contractor need not send a letter of recommendation to the State or RO. However, if it appears that significant data (e.g., legal business name) about the provider has changed or the contractor has reason to believe that the provider may no longer meet State or CMS requirements, the contractor should send a notification letter to the State and RO.

- Sections 3.1 and 3.2 of this manual apply to the "*complete* applications" described in this section 5.7. Thus, for instance, if the provider submits an application containing a missing signature, the contractor may return the application per section 3.2.

To reiterate, a provider must furnish a complete CMS-855 application if it is submitting any change request and the provider is not in PECOS. (For purposes of this requirement, the term "change request" includes EFT changes.) This policy is an expansion and clarification of the previous mandate that a complete CMS-855 application is required if the provider is submitting an EFT change and has never completed a CMS-855 application before. (See section 7.1.1 of this manual for more information.)

6.2 – Denials

(Rev. 173; Issued: 11-13-06; Effective/Implementation Dates: 11-15-06)

Per 42 CFR §424.530(a), carriers must deny, and intermediaries must recommend a denial of, an enrollment application if any of the situations described below are present. (Carriers should only recommend denial in the case of ASCs and portable x-ray suppliers.) The carrier/RO must provide appeal rights. A denial is effective 30 calendar days after the contractor sends its denial notice to the provider. *Note that a denial (or recommendation to deny) can be made during the prescreening phase.*

Denial Reason 1 (42 CFR §424.530(a)(1))

The provider or supplier is determined not to be in compliance with the enrollment requirements described in this section or in the enrollment application applicable for its provider or supplier type and has not submitted a plan of corrective action as outlined in part 488 of this chapter.

Denial Reason 2 (42 CFR §424.530(a)(2))

The provider or supplier, or any owner, managing employee, authorized or delegated official, medical director, supervising physician, or other health care personnel of the provider or supplier who is required to be reported on the CMS-855 is—

- Excluded from the Medicare, Medicaid, or any other Federal health care program, as defined in 42 CFR §1001.2, in accordance with section 1128, 1128A, 1156, 1842, 1862, 1867 or 1892 of the Social Security Act, or

- Debarred, suspended, or otherwise excluded from participating in any other Federal procurement or nonprocurement program or activity in accordance with section 2455 of the Federal Acquisition Streamlining Act.

Denial Reason 3 (42 CFR §424.535(a)(3))

The provider, supplier, or any owner of the provider or supplier was, within the 10 years preceding enrollment or revalidation of enrollment, convicted of a Federal or State felony offense that CMS has determined to be detrimental to the best interests of the program and its beneficiaries. Offenses include--

- Felony crimes against persons, such as murder, rape, assault, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions.

- Financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions.

- Any felony that placed the Medicare program or its beneficiaries at immediate risk, such as a malpractice suit that results in a conviction of criminal neglect or misconduct.

- Any felonies that would result in mandatory exclusion under section 1128(a) of the Social Security Act.

Denial Reason 4 (42 CFR §424.530(a)(4))

The provider or supplier certified as "true" false or misleading information on the enrollment application to be enrolled or maintain enrollment in the Medicare program. (The contractor shall contact its DPSE contractor liaison prior to issuing or recommending denial of an application on this ground.)

Denial Reason 5 (42 CFR §424.530(a)(5))

The CMS determines, upon onsite review or other reliable evidence, that the provider or supplier is not operational to furnish Medicare covered items or services, or does not meet Medicare enrollment requirements to furnish Medicare covered items or services. This includes the following situations:

- The applicant does not have a license(s) or is not authorized by the Federal/State/local government to perform the services for which it intends to render. (In the denial letter, the contractor shall list the appropriate citations, e.g., §1861(r) or §1861(s) of the Social Security Act.)

- The applicant does not have a physical business address or mobile unit where services can be rendered and/or does not have a place where patient records are stored to determine the amounts due such provider or other person (as set forth in §1833(e) of the Social Security Act.)

- The applicant does not meet CMS regulatory requirements for the specialty. (In the denial letter, the contractor shall list the appropriate regulation citation.)

- The applicant does not qualify as a provider of services or supplier of medical and health services. An entity seeking Medicare payment must be able to receive reassigned benefits from physicians in accordance with the Medicare reassignment statute in §1842(b)(6) of the Act (42 U.S.C. 1395u(b)).

- The applicant does not provide a valid SSN/EIN for the applicant, owner, partner,

  managing organization/employee, officer, director, ambulance crewmember, medical director, and/or delegated or authorized official.

- A home health agency (HHA) does not meet the capitalization requirements per 42 CFR § 489.28.

When a decision to deny is made, the carrier shall send a letter to the supplier identifying the reason(s) for denial and furnishing appeal rights. The letter shall follow the format of that shown in section 14 of this manual.

If a recommendation to deny is made (for certified suppliers and providers), the contractor shall send a letter of recommendation for denial to the applicable State agency, with a copy going to the RO's survey and certification unit. The letter shall contain the same data elements listed in section 6.1.2 of this manual; the contractor shall also follow the same procedures for furnishing notification to the State, the RO, and the provider identified in section 6.1.2 above.

It is imperative that all denial (or recommendation for denial) letters contain sufficient factual and background information so that the reader understands exactly why the denial occurred. It is not enough to simply list one of the eight denial reasons. For instance, if an application is denied based on falsification, the carrier must identify in its letter the falsified information, how and why the carrier determined it was false, etc. If there were multiple reasons for denial, the letter shall state as such.

A provider or supplier that is denied enrollment in the Medicare program cannot submit a new enrollment application until the following has occurred:

- If the denial was not appealed, the provider or supplier may reapply after its appeal rights have lapsed.

- If the denial was appealed, the provider or supplier may reapply after it received notification that the determination was upheld.

If the denial was due to adverse activity (sanction, exclusion, debt, felony) of an owner, managing employee, an authorized or delegated official, medical director, supervising physician, or other health care personnel of the provider or supplier furnishing Medicare services, the denial may be reversed if the provider or supplier submits proof that it has

terminated its business relationship with that individual or organization within 30 days of the denial notification. The contractor, however:

- Need not solicit or ask for such proof in its denial letter. It is up to the provider to furnish this data on its own volition.

- Has the ultimate discretion to determine whether sufficient “proof” exists.

7.1 – General Procedures

(Rev. 173; Issued: 11-13-06; Effective/Implementation Dates: 11-15-06)

Unless otherwise specified in this manual, if an enrolled provider is adding, deleting, or changing information under its same tax identification number, it must report this change using the applicable CMS-855 form. Letterhead is not permitted.

The provider shall furnish the changed data in the applicable section of the form and sign and date the certification statement. In addition:

- **Unsolicited Additional Information** - Any new or changed information submitted by a provider prior to the date the contractor finishes processing a change request is considered an update to that original change request. It is not considered to be a separate change of information. Thus, suppose a provider submits a change of information. On the 24th day, it submits more information that it wants changed. Because the contractor had 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.

- ***Unavoidable Phone Number or Address Changes*** *- Any change in the provider's phone number or address that is not caused by the provider (i.e., area code change, municipality renames the provider's street) must still be updated via the CMS-855.*

- **Denials of Change Requests –** The contractor shall deny (or recommend denial of) a provider's change request if any of the situations identified in section 6.2 above are implicated. In the case of a certified supplier or certified provider, the contractor shall send the recommendation for denial to the State and RO if the change involves any of the situations identified in the previous bullet (e.g., stock transfer, addition of practice location.)

- **Verification of Signatures/Section 6** – Unless the change request involves a change to EFT information, the contractor is not required to verify signatures for changes of information (e.g., matching the authorized or delegated official's signature on the change request against that same official's signature already on file). However, if the signer has never been reported in section 6 of the CMS-855, section 6 must be completed in full with information about the individual. The contractor shall check the individual against Qualifier.net and note in the enrollment file that this was performed. This policy applies regardless of whether the provider has a CMS-855 on file already.

- **Notifications** – For changes of information that do not involve or require RO approval (e.g., CMS-855I changes, CMS-855B changes not involving ASCs or portable x-ray suppliers, minor CMS-855A changes), the contractor shall furnish written, e-mail, or telephonic confirmation to the provider that the change has

been made. Document (per section 10 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 to the provider that this change has been made.

7.1.1 – Changes of Information and Complete CMS 855 Applications
(Rev. 173; Issued: 11-13-06; Effective/Implementation Dates: 11-15-06)

A provider must submit a complete CMS-855 application if it is not in PECOS and is submitting <u>any</u> change request. (For purposes of this requirement, the term "change request" includes EFT changes.) This policy is an expansion and clarification of the previous requirement that a complete CMS-855 application is required if the provider is submitting an EFT change and has never completed a CMS-855 application before. For purposes of this policy, it is immaterial: (1) whether the provider, bank, or other party (e.g., change in bank name via merger; local government changes the street name) was responsible for triggering the changed data, or (2) the signer of the change request or EFT form already has a signature on file with the contractor.

If the contractor receives a change request from a provider that is not in PECOS, the contractor shall not return the application/change request. It shall simply develop for the entire application in a manner similar to the procedures described in section 3.1 and 5.3 of this manual. In other words, it shall treat the matter as a request for additional information. As with all requests for additional information, the provider has 60 days to submit the solicited data, meaning the provider has 60 calendar days from the date of the contractor's request to furnish the entire CMS-855 application. During this period, the contractor should "hold" (i.e., not process) the change request until the entire application arrives; no L & T record shall be created in PECOS at this point.

If the provider fails to submit a complete application within the aforementioned 60-day period, the contractor shall take steps to revoke the provider's billing privileges in accordance with existing revocation proceedings

If the provider does submit the application, the contractor shall process the CMS-855 in full accordance with all of the instructions in this manual. This includes:

- *Processing the complete application within 60 calendar days of receipt of that application. Suppose the contractor received the change request on March 1. It requested a complete application from the provider on March 10. The provider furnished the application on April 1. The contractor has until June 1 to process the complete CMS-855.*

- *Verifying all data elements on the CMS-855, just as it would with an initial enrollment application. The contractor shall not approve the change request until all data on the CMS-855 has been validated. Moreover, the provider must submit all supporting documentation with the application.*

- *Creating an L & T record and enrollment record in PECOS prior to approving the change request. (This is an exception to the general rule that an L & T record must be created no later than 15 calendar days after the contractor received the application.) It should be treated as an initial enrollment in PECOS; internally,*

the contractor shall treat it as a change of information. As the completed application will presumably incorporate the changed data reported on the initial CMS-855 change request, the contractor shall not take two separate counts (one initial and one change request) for the transaction.

7.3 – Voluntary Terminations

(Rev. 173; Issued: 11-13-06; Effective/Implementation Dates: 11-15-06)

Voluntary terminations shall be processed in accordance with the timeframes in section 2.2 of this manual (e.g., 80 percent within 45 calendar days).

If the termination involves a certified provider, ASC, or portable x-ray supplier, the contractor shall make a recommendation to the State and RO. The contractor shall not terminate the provider in its system until the RO issues its final approval of the matter.

Upon receipt of a voluntary termination, the contractor may ask the provider to complete the "Special Payments" portion of section 4 so that future payments can be sent to the provider. If the provider has no "Special Payments" address on file, it should be included in the same transaction as the termination (i.e., one count). If the provider is changing an existing address, it should be treated as a separate change request (i.e., one termination and one change request). The provider is not required to submit a CMS-588 in conjunction with a termination.

8 – Electronic Fund Transfers (EFT)

(Rev. 173; Issued: 11-13-06; Effective/Implementation Dates: 11-15-06)

If a provider that is not in PECOS wants to make any change to any of its EFT information (e.g., bank routing number), it must submit a complete CMS-855 form before the contractor can effectuate the change. It is immaterial: (1) whether the provider or the bank (e.g., change in bank name via merger) was responsible for triggering the changed data or (2) the signer of the CMS-588 already has a signature on file with the contractor. (For more information, see section 7.1.1 of this manual.)

In addition:

- ***EFT Requirement*** - All providers *(including Federal, State and local governments)* entering the Medicare program for the first time must use EFT in order to receive payments. Moreover, any provider not currently on EFT that submits any change to its existing enrollment data must also submit a CMS-588 form *and receive payments via EFT. If the provider's bank of choice does not or will not participate in the provider's proposed EFT transaction, the provider must select another financial institution.*

- **Verification** - The contractor shall verify that all EFT changes must comply with Pub. 100-04, chapter 1, section 30.2.5, Payment to Bank.) In short, all EFT changes must be verified and validated.

- **Sent to the Wrong Unit** - If a provider submits its EFT change request to the contractor but not to the latter's enrollment unit, the recipient unit shall forward it to the enrollment unit, which shall then process the change. The enrollment unit is ultimately responsible for processing EFT changes. As such, while it may send the original EFT form back to the recipient unit, the enrollment unit shall keep a copy of the EFT form and append it to the provider's CMS-855 in the file.

- **CMS 588 Changes and PECOS** – In situations where the only data the provider is changing is on the CMS 588 (e.g., no data is changing on the CMS-855), the contractor shall process the EFT change *using the timeframes cited in section 2.2 of this manual*. However, the contractor shall not create an L & T record*, though it is free to internally track the number of CMS-588 applications it processes.*

- **Processing Timeframes** - *In situations where the provider is in PECOS and submits an EFT change, the change request shall be treated like any other change request for purposes of timeliness (i.e., 80 percent within 45 calendar days). If the provider is not in PECOS, the contractor shall follow the instructions in section 7.1.1 of this manual.*

- **Comparing Signatures** - If the contractor receives an EFT change request, it shall compare the signature thereon with the same official's signature on file to ensure that it is indeed the same person.

  If the person's signature is not already on file, the contractor shall request that the individual complete section 6 of the CMS-855 and furnish his/her signature in section 15 or 16 of the CMS-855. (This shall be treated as part of the EFT change request for purposes of timeliness and reporting.)

- **Suspicious Changes** - It is not necessary – as a matter of course – for contractors to review the provider's recent claims activity prior to approving a change in EFT data. Contractors should, however, review the provider's recent claims activity if it has suspicions about the propriety of the change request. If necessary, the contractor can refer the matter to the PSC for its information.

- **Bankruptcies and Garnishments** – In general, all court orders take precedence over the instructions in this manual. However, if the contractor receives a copy of a court order to send payments to a party other than the provider, the contractor shall contact the RO's Office of General Counsel.

- ***Closure of Bank Account*** *– There may be situations where a provider has closed its bank/EFT account but will remain enrolled in Medicare. The contractor shall place the provider on payment withhold until an EFT agreement (and CMS 855, if applicable) is submitted and approved by the contractor. If such an agreement is not submitted within 90 days after the contractor first learned that the account was closed, the contractor shall commence revocation procedures in accordance with the instructions in this manual.*

- ***Reassignments*** *– If a physician or practitioner is reassigning all of his/her benefits to another supplier, neither the practitioner nor the group needs to submit a CMS-588 form. This is because (1) the practitioner is not receiving payment directly, and (2) accepting a reassignment does not qualify as a change of information request. Of course, if the group later submits a change of information request (e.g., adding a new owner in section 6), the group must submit an EFT agreement.*

In situations where a non-certified supplier (e.g., physician, ambulance company) voluntarily withdraws from Medicare and needs to obtain its final payments, the carrier shall send the payments to the provider's EFT account of record. If the account is defunct, the carrier can send it to the provider's "special payments" address or, if none is on file, any of the provider's practice locations on record. If neither the EFT account nor the addresses discussed above are in existence, the provider shall submit a CMS-855 or CMS 588 request identifying where it wants payments to be sent.

9 - Revalidation

(Rev. 173; Issued: 11-13-06; Effective/Implementation Dates: 11-15-06)

Per 42 CFR § 424.515, Medicare providers and suppliers (other than DMEPOS suppliers) must resubmit and recertify the accuracy of their enrollment information every five years in order to maintain Medicare billing privileges. *Contractors may initiate revalidation activities at any time during the fiscal year.*

The following principles apply to revalidation:

- *The processing times for "initial" applications – outlined in section 2.1 of this manual – apply to revalidation applications.*

- *Per 42 CFR § 424.515, a provider whom the contractor requested to furnish all requested information (as part of the revalidation) must do so within 60 calendar days after the date the contractor notified the provider of the need to revalidate. If the provider fails to do so, the contractor shall revoke the provider's billing privileges using existing revocation procedures.*

- *The provider must submit all required documentation with its application, even if such documentation is already on file with the contractor.*

- *The contractor shall verify all data furnished on the application – just as it would with an initial enrollment – using the procedures identified in this manual (e.g., section 5.2)*

11.3 – Provider-Based

(Rev. 173; Issued: 11-13-06; Effective/Implementation Dates: 11-15-06)

The contractor shall adhere to the following rules regarding the enrollment of provider-based entities:

- **Certified Provider Initially Enrolling –** Suppose an HHA or other entity wishes to enroll and become provider-based to a hospital. The provider must enroll with the intermediary as a separate entity. It cannot be listed as a practice location on the hospital's CMS-855A.

- **Certified Provider Changing its Provider-Based Status –** If a certified provider *is changing* its status from provider-based to freestanding or vice versa, it need not submit any updates to its CMS-855A enrollment.

- **Group Practice Initially Enrolling –** If a group practice *is enrolling* in Medicare *and will* become provider-based to a hospital, *the group generally must enroll with the carrier if it wants to bill for practitioner services. The group would also need to be listed or added as a practice location on the hospital's CMS 855A.*

- **Group Practice Changing from Provider-Based to Freestanding** *– In this situation, the hospital should submit a CMS-855A change request that deletes the clinic as a practice location. The group may also need to change the type of clinic it is enrolled as; this may require a brand new CMS 855B.*

- **Group Practice Changing from Freestanding to Provider-Based** *– Here, the hospital shall submit a CMS-855A change request adding the group as a practice location. The group may also need to change the type of clinic it is enrolled as; this may require a brand new CMS 855B.*

Unless the RO specifically dictates otherwise, the intermediary shall not delay the processing of any additional practice locations pending receipt of provider-based attestations or RO concurrence of provider-based status.

11.6 – *Participation (Par)* Agreements *and the Acceptance of Assignment*

(Rev. 173; Issued: 11-13-06; Effective/Implementation Dates: 11-15-06)

Carriers shall abide by the instructions in Pub. 100-04, chapter 1, sections 30 through 30.3.12.3 when handling matters related to par agreements and assignment. Queries related to the interpretation of such instructions shall be referred to the responsible CMS component.

11.7 - Opt-Out

(Rev. 173; Issued: 11-13-06; Effective/Implementation Dates: 11-15-06)

There are physicians and other individual practitioners who do not wish to enroll in the Medicare program. Physicians and practitioners (but not organizations) can "opt-out" of Medicare. This means that neither the physician nor the beneficiary submits the bill to Medicare for services performed. Instead, the beneficiary pays the physician out-of-pocket and neither party is reimbursed by Medicare. In fact, a private contract is signed between the physician and the beneficiary that states, in essence, that neither one can receive payment from Medicare for the services that were performed. (The contract, of course, must be signed before the services are provided so the beneficiary is fully aware of the physician's opt-out status.) Moreover, the supplier must submit an affidavit to Medicare expressing his/her decision to opt-out of the program. The provider enrollment unit must process these affidavits.

The difference between opting-out and not accepting assignment is relatively straightforward. If the practitioner opts-out, neither he/she nor the beneficiary can bill Medicare. If the practitioner chooses not to accept assignment, he/she must still enroll in Medicare and must submit the bill to the carrier.

(For additional information on "opt-out," see Pub. 100-02, chapter 15, section 40.)

In an emergency care or urgent care situation, a physician or practitioner who opts out may treat a Medicare beneficiary with whom he or she does not have a private contract. In those circumstances, the physician or practitioner must complete a CMS-855 application after the emergency services were provided.

11.8 - Manufacturers of Replacement Parts/Supplies for Prosthetic Implants or Implantable Durable Medical Equipment (DME) Surgically Inserted at an ASC

(Rev. 173; Issued: 11-13-06; Effective/Implementation Dates: 11-15-06)

Since carriers make payments for implantable prosthetics and DME to hospitals, physicians or ASCs, carriers shall not enroll manufacturers of implantable or non-implantable and prosthetics DME into the Medicare program. Manufacturers of non-implantable prosthetics and DME and replacement parts and supplies for prosthetic implants and surgically implantable DME may enroll in the Medicare program as a supplier with the NSC if they meet the definition of a supplier as well as the requirements set forth in 42 CFR § 424.57.

11.9 – Enrolling Indian Health Service (IHS) Facilities as Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Suppliers

(Rev. 173; Issued: 11-13-06; Effective/Implementation Dates: 11-15-06)

The NSC shall enroll IHS facilities as DMEPOS suppliers in accordance with the general enrollment procedures cited in chapter 10 and the statement of work contained in the NSC contract with Medicare, with the addition of the special procedures and clarifications cited in this section.

For enrollment purposes Medicare recognizes two types of IHS facilities. They are: a) those facilities wholly owned and operated by the IHS and b) facilities which are owned by the IHS but tribally operated or totally owned and operated by a tribe. CMS shall provide the NSC with a list of IHS facilities which distinguish between these two types.

On the list the NSC shall use the column entitled, "FAC OPERATED BY", for this purpose.

1. ***Completion of the Medicare Supplier Enrollment Application: CMS-855S Application for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers.*** *The CMS-855S shall be completed in accordance with the instructions shown therein except as follows:*

    a. *Facilities that are totally owned and operated by the IHS are considered a governmental organization. An Area Director of the IHS must sign the section 15 Certification Statement of the CMS – 855S, be listed in section 6 of the form and sign the letter required by section 5 of the form which attests that the IHS will be legally and financially responsible in the event that there is any outstanding debt owed to CMS.*

    b. *Facilities that are tribally operated are considered tribal organizations. The section 15 Certification Statement of the CMS – 855S must be signed by a tribal official who meets the definition of an authorized official in accordance with the page 2 definitions shown on the CMS – 855S. The same authorized official must be listed in section 6 of the CMS – 855S and must sign the letter required by section 5 of the form which attests that the tribe will be legally and financially responsible in the event that there is any outstanding debt owed to CMS.*

2. The DMEPOS Supplier Standards, Exceptions for Liability Insurance and State Licensure, and Site Visits

All IHS facilities, whether operated by the IHS or a tribe, enrolled by the NSC, shall meet all required standards as verified by the review procedures for all other DMEPOS suppliers except as discussed herein.

All IHS facilities, whether operated by the IHS or a tribe, shall be exempt from the comprehensive liability insurance requirements under 42 CFR Sec. 424.57(c)(10).

All IHS facilities, whether operated by the IHS or a tribe, shall be exempt from the requirement to provide any State Licenses for their facility/business. For example, if the DMEPOS supplier indicates on its application that it will be providing hospital beds and is located in a State that requires a bedding license, such licensure is not required. However, if they provide a DMEPOS item that requires a licensed professional in order to properly provide the item, they shall provide a copy of the professional license. The licensed professional can be licensed in any State or have a Federal license. For example, a pharmacy does not need a pharmacy license, but shall have a licensed pharmacist.

Site visits shall be required for all IHS facilities (whether operated by the IHS or a tribe) enrolling for DMEPOS. This includes all hospitals and pharmacies.

3. Provider Education for IHS Facilities

The NSC shall modify its Web site to include the information contained in this section which is specific to enrollment of IHS facilities (whether operated by the IHS or a tribe).

4. Specialty Codes

The NSC shall apply the specialty code A9 (IHS) for all IHS enrollments (whether operated by the IHS or a tribe). However, the specialty code A9/A0 shall be applied for facilities that are IHS/tribal hospitals. Additionally other specialty codes should be applied as applicable (e.g., pharmacy).

14 – Model Correspondence Language

(Rev. 173; Issued: 11-13-06; Effective/Implementation Dates: 11-15-06)

A. Rejection

"Dear Entity:

We received your enrollment application on _____. We sent to you a letter on _____ asking for (additional or clarifying) information. Unfortunately, you did not respond (or only sent a portion of the requested information.) Therefore, we must reject your application. If, at a later date, you wish to enroll in Medicare, you will need to submit another CMS-855 enrollment application."

B. Returns

"Dear Entity:

We received your enrollment application on _____. Unfortunately, we are returning your application because _____. If, at a later date, you wish to enroll in Medicare, you will need to submit another CMS-855 enrollment application."

C. Denials

“Dear Supplier:

We received your enrollment application on _____. Unfortunately, your request to participate in the Medicare program is denied. After careful review of your application, it was determined that you do not meet the conditions of enrollment or meet the requirement to qualify as a health care supplier because _____

You may, of course, take steps to correct the deficiencies and reapply to establish your eligibility.

(Insert standard appeals language.)

(See section 19 of this manual for more information on correspondence language pertaining to appeals.)

15 – PECOS *– General Information*

(Rev. 173; Issued: 11-13-06; Effective/Implementation Dates: 11-15-06)

A. *Introduction*

The PECOS captures all enrollment information contained on the CMS-855, identifies relationships between Medicare providers, tracks each enrollment application, performs inquiries, and produces reports. It monitors each enrollment application from the time the enrollment form is received until the contractor finishes processing it. PECOS will also be used to update enrollment information and to communicate with the claims processing system.

B. Timeframes

As stated in section 2.3 of this manual, the contractor shall 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. In addition, 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' 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). (It does not apply to applications that are returned under sections 3.2 of this manual.)

For all applications that fall within the "Changes of Information" category in section 2.2 of this manual, the contractor shall update the provider's enrollment record in PECOS prior to its completion of the processing of the application. *An exception to this is if the application was denied (or a recommendation for denial was made); here, the update need not be made, and the PECOS status should simply be changed to reflect the denial.*

C. Skeletal Records

Contractors shall *not establish* skeletal records (as that term is defined in CMS Change Request 2296, dated August 21, 2002) in PECOS under any circumstances. Enrollment records shall only be created when *a complete* CMS-855 is submitted.

D. Non-CMS-855 Forms

There are instances where the contractor processes non-CMS-855 forms and other documentation relating to provider enrollment. Such activities include:

- EFT agreements (CMS 588) submitted alone;

- "Do Not Forward" issues;
- Par agreements (CMS 460);
- Returned remittance notices;
- Informational letters received from other contractors;
- Diabetes self-management notices;
- Verification of new billing services;
- Paramedic intercept contracts;
- 1099 issues that need to be resolved.

Unless specifically stated otherwise in this manual, the contractor shall not create an L & T record for any non-CMS-855 document or activity other than the processing of par agreements. The contractor should track and record all other activities internally.

E. Production vs. Validation

PECOS currently has two environments – PECOS Production and PECOS Validation. Users can access PECOS Production using the PECOS Production icon, and users can access PECOS Validation using the PECOS Validation icon.

PECOS Production is used for processing day-to-day enrollment applications. PECOS Validation is used for testing new releases of PECOS and training new staff on PECOS; it is not to be used for day-to-day processing.

F. Special PECOS Rules

In addition to the PECOS instructions outlined in this section 15 and throughout this manual, the contractor shall abide by the following:

- **Multiple States in the Same Contractor Jurisdiction –** If a provider wishes to enroll in several States within the same contractor jurisdiction, the contractor must create a separate enrollment record for each State – even if the provider only needed to submit a single CMS-855 form encompassing all the States.

- **Adding an Individual to an Existing Group**

    - *If the group is not in PECOS, the group* shall submit a *complete* CMS-855B, along with the CMS-855R. The CMS-855B shall be processed like an initial enrollment application, thus requiring the creation of a new enrollment record. The CMS-855R should not be processed until the group's enrollment record has been put in "approved" status.

    - *If the individual is not in PECOS,* the person shall submit a *complete* CMS-855I, along with the CMS-855R. The CMS-855I shall be processed like an initial enrollment application, thus requiring the creation of a new enrollment record. The CMS-855R should not be processed until the person's enrollment record has been put in "approved" status.

    - For a CMS-855R received for an individual already enrolled with Medicare but who is not in PECOS, the person shall submit a *complete* CMS-855I, along with the CMS-855R. The CMS-855I shall be processed like an initial enrollment application, thus requiring the creation of a new enrollment record. The CMS-855R should not be processed until the person's enrollment record has been put in "approved" status.

- ***Future Effective Dates*** *– In situations where the contractor cannot enter effective dates into PECOS because the provider, practice location, etc., is not yet established, the contractor may use the authorized official's date of signature as the temporary effective date. (This typically happens with certified providers, ASCs, and portable x-ray suppliers.) Once the provider and actual effective date is established (e.g., the tie-in notice is received), the contractor shall go into PECOS and change the effective date.*

15.1 – PECOS Communication and Coordination

(Rev. 173; Issued: 11-13-06; Effective/Implementation Dates: 11-15-06)

A. Communications with Other Contractors

Medicare contractors (carriers and fiscal intermediaries) create Associate and Enrollment Records in the Provider Enrollment, Chain and Ownership System (PECOS). Ownership of an Associate or an Enrollment Record belongs to the contractor within whose jurisdiction the provider/supplier is located. PECOS permits only the contractor who created the Associate or the Enrollment Record (known as the owning contractor) to make any updates, changes, or corrections to those records. (In other words, the owning contractor is the only contractor that can make changes to the associate record.)

On occasion, the updates, changes, or corrections do not come to the attention of the owning contractor, but instead go to a different carrier or fiscal intermediary. In those situations, the contractor that has been notified of the update/change/correction (the "requesting" contractor) must convey the update/change/correction information to the owning contractor so that the latter can access the record in PECOS and make the update/change/correction.

The requesting contractor may notify the owning contractor via fax of the need to update/change/correct information in a provider's PECOS record. When the requesting contractor notifies the owning contractor of the needed update/change/correction, the following information must be furnished:

1. *The legal business name of the provider;*
2. *The provider's Medicare identification number;*
3. *The provider's NPI (by including a copy of the provider's NPI notification); and*
4. *The updated/changed/corrected data (by including a copy of the appropriate section of the CMS-855).*

The owning contractor, within 7 calendar days of receiving the requesting contractor's request for a change to a PECOS record, shall make the change in the PECOS record and notify the requesting contractor that the change has been made. Notification may occur by fax, e-mail, or telephone.

If the owning contractor – for whatever reason - feels uncomfortable about making the change, it shall contact its CO DPSE contractor liaison for guidance. Note that the owning contractor may ask the requesting contractor for any additional information about the provider it deems necessary (e.g., IRS documentation, licenses, Qualifier.net data). However, the former should not be overly obstructionist about the matter.

It is not necessary for the contractor to ask the provider for a CMS-855 change of information in associate profile situations. That is, if another intermediary asks the contractor/record holder to make a change to the record, the record holder need not ask the provider to submit a CMS-855

change request to it. It can simply work off of the CMS-855 copy that the requesting intermediary or carrier sent/faxed to the contractor. For instance, suppose Provider X is enrolled in two different intermediary jurisdictions – A and B. The provider enrolled with "A" first; its legal business name was listed as "John Brian Smith Hospital." It later enrolls with "B" as "John Bryan Smith Hospital." "B" has verified that "John Bryan Smith Hospital" is the correct name and sends a request to "A" to fix the name. "A" is not required to ask the provider to submit a CMS-855A change of information. It can simply use the CMS-855A copy that it received from "B."

B. Transferring Ownership of PECOS Records

A contractor may request that CMS transfer ownership of a particular provider's PECOS associate record to another contractor. The contractor shall send its request to its DPSE contractor liaison with the rationale for the request (e.g., provider has moved to another contractor's jurisdiction). The requesting contractor should also include an e-mail from the "new" contractor agreeing to the transfer. DPSE will review the request accordingly.

16 – Reserved for Future Use

(Rev. 173; Issued: 11-13-06; Effective/Implementation Dates: 11-15-06)

18.2 - Provider Enrollment Inquiries

(Rev. 173; Issued: 11-13-06; Effective/Implementation Dates: 11-15-06)

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).