

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 372	Date: March 25, 2011
	Change Request 7232

SUBJECT: Effective Date of Certified Provider or Supplier Agreement or Approval

I. SUMMARY OF CHANGES: The final FY 2011 IPPS rule was published on August 16, 2010 (75 FR50042) and is effective October 1, 2010. Several provisions in the rule directly affect areas of survey and certification responsibility. 42 CFR 489.13 governs the determination of the effective date of a Medicare provider agreement or supplier approval for health care facilities that are subject to survey and certification. §489.13 has been revised to make it clearer that the date of a Medicare provider agreement or supplier approval may not be earlier than the latest date on which all applicable federal requirements have been met, and that such requirements include review and verification of an application to enroll in the Medicare program by CMS's legacy fiscal intermediary (FI), legacy carrier, or Medicare Administrative Contractor (MAC).

EFFECTIVE DATE: October 1, 2010

IMPLEMENTATION DATE: April 25, 2011

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
N	15/17/17.4/Certified Provider or Supplier Agreement or Approval
N	15/7/7.4/Tie-In Notices

III. FUNDING:

For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs):

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

For Medicare Administrative Contractors (MACs):

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

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

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

Attachment - Business Requirements

Pub. 100-08	Transmittal: 372	Date: March 25, 2011	Change Request: 7232
-------------	------------------	----------------------	----------------------

SUBJECT: Effective Date of Certified Provider or Supplier Agreement or Approval

Effective Date: October 1, 2010

Implementation Date: April 25, 2011

I. GENERAL INFORMATION

A. Background: The final FY 2011 Inpatient Prospective Payment Systems (IPPS) rule was published on August 16, 2010 (75 FR50042) and was effective October 1, 2010. Several provisions in the rule directly affect areas of survey and certification responsibility.

42 CFR 489.13 governs the determination of the effective date of a Medicare provider agreement or supplier approval for health care facilities that are subject to survey and certification. §489.13 has been revised to make it clearer that the date of a Medicare provider agreement or supplier approval may not be earlier than the latest date on which all applicable federal requirements have been met, and that such requirements include review and verification of an application to enroll in the Medicare program by CMS's legacy fiscal intermediary (FI), legacy carrier, or Medicare Administrative Contractor (MAC).

These clarifications were necessary because a September 28, 2009 decision of the Appellate Division of the Department Appeals Board (DAB) interpreted §489.13 as not including enrollment application processing among Federal requirements that must be met. In that case a State Agency (SA) had conducted a survey of an applicant on July 6, 2007, prior to receiving the November 21, 2007 notice from the legacy FI that was recommending approval of the applicant's enrollment application. The CMS Regional Office (RO) issued a provider approval effective November 21, 2007, consistent with our traditional interpretation of §489.13. The DAB, however, ruled that the effective date must be July 6, 2007. The DAB agreed with the applicant in this case that the requirement for the Medicare contractor to verify and determine whether an application should be approved is not a requirement for the provider to meet [under §489.13], but rather a requirement for Medicare contractor action (DAB Decision No. 2271, page 5).

Although SAs and accreditation organizations (AOs) are aware that, in accordance with Section 2003B of the State Operations Manual (SOM), they should not perform a survey of a new facility until the MAC/legacy FI/legacy carrier has provided notice that the information provided on the enrollment application has been verified and enrollment is being recommended, circumstances do occur when the sequence is reversed. AOs, in particular, often find it challenging to confirm whether the MAC/legacy FI/legacy carrier has completed its review and made a recommendation. This is because AOs are dependent upon the applicant providing copies of the pertinent notices. When the survey occurs prior to the enrollment verification activities, we believe it is essential that the provider agreement or supplier approval date be based on the later date, i.e., the date the contractor determined that the enrollment application verification. There are other Federal requirements not related to a facility's survey, such as the provision of required Office for Civil Rights documentation and additional federal requirements specific to certain provider types, such as IPPS exclusion requirements for certain types of hospitals, capitalization and surety bond requirements for home health agencies, among others.

Accordingly, the revised rule explicitly states in §489.13(b) that:

“Federal requirements include, but are not limited to –

- (1) Enrollment requirements established in part 424, Subpart P, of this chapter. CMS determines, based upon its review and verification of the prospective provider's or supplier's enrollment application, the date on which enrollment requirements have been met;

- (2) The requirements identified in §§489.10 and 489.12; and
- (3) The applicable Medicare health and safety standards, such as the applicable conditions of participation, the requirements for participation, the conditions for coverage, or the conditions for certification.

B. Policy: The final FY 2011 IPPS rule was published on August 16, 2010 (75 FR50042) and is effective October 1, 2010. Several provisions in the rule directly affect areas of survey and certification and provider enrollment responsibilities. 42 CFR 489.13 governs the determination of the effective date for provider agreement or supplier approval for facilities requiring certification.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B M A C	D M M A C	F I M A C	C A I E R	R H I S	Shared- System Maintainers	F I S S	M C S	V M S	C W F
7232.1	Contractors shall apply the FY2011 IPPS Rule Adopted that is applicable to 42 CFR 489.13(b), governing the determination for the effective date for provider agreement or supplier approval for facilities requiring certification.	X		X	X	X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B M A C	D M M A C	F I M A C	C A I E R	R H I S	Shared- System Maintainers	F I S S	M C S	V M S	C W F
7232.2	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program	X		X	X	X					

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B	D M E	F I	C A R I E R	R H I	Shared-System Maintainers				OTH ER
		M A C	M A C				F I S S	M C S	V M S	C W F	
	correctly.										

IV. SUPPORTING INFORMATION

Section 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:
	None.

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): Tolla Anderson, tolla.anderson@cms.hhs.gov, 410-786-1786

Post-Implementation Contact(s): Contact your Contracting Officer’s Technical Representative (COTR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs):

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

Section B: For Medicare Administrative Contractors (MACs):

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

Medicare Program Integrity Manual

Chapter 15 - *Medicare Enrollment*

Table of Contents (Rev. 372, 03-25-11)

17.4 Certified Provider or Supplier Agreement or Approval

17.4 Certified Provider or Supplier Agreement or Approval
(Rev. 372, Issued: 03-25-11, Effective: 10-01-10, Implementation: 04-25-11)

The final FY 2011 IPPS rule was published on August 16, 2010 (75 FR50042) and is effective October 1, 2010. Several provisions in the rule directly affect areas of survey and certification responsibility.

42 CFR 489.13 governs the determination of the effective date of a Medicare provider agreement or supplier approval for health care facilities that are subject to survey and certification. §489.13 has been revised to make it clearer that the date of a Medicare provider agreement or supplier approval may not be earlier than the latest date on which all applicable federal requirements have been met, and that such requirements include review and verification of an application to enroll in the Medicare program by CMS's legacy fiscal intermediary (FI), legacy carrier, or Medicare Administrative Contractor (MAC).

These clarifications were necessary because a September 28, 2009 decision of the Appellate Division of the Department Appeals Board (DAB) interpreted §489.13 as not including enrollment application processing among Federal requirements that must be met. In that case a State Agency (SA) had conducted a survey of an applicant on July 6, 2007, prior to receiving the November 21, 2007 notice from the legacy FI that was recommending approval of the applicant's enrollment application. The CMS Regional Office (RO) issued a provider approval effective November 21, 2007, consistent with our traditional interpretation of §489.13. The DAB, however, ruled that the effective date must be July 6, 2007. The DAB agreed with the applicant in this case that the requirement for the Medicare contractor to verify and determine whether an application should be approved is not a requirement for the provider to meet [under §489.13], but rather a requirement for Medicare contractor action (DAB Decision No. 2271, page 5).

Although SAs and accreditation organizations (AOs) are aware that, in accordance with Section 2003B of the State Operations Manual (SOM), they should not perform a survey of a new facility until the MAC/legacy FI/legacy carrier has provided notice that the information provided on the enrollment application has been verified and enrollment is being recommended, circumstances do occur when the sequence is reversed. AOs, in particular, often find it challenging to confirm whether the MAC/legacy FI/legacy carrier has completed its review and made a recommendation. This is because AOs are dependent upon the applicant providing copies of the pertinent notices. When the survey occurs prior to the enrollment verification activities, we believe it is essential that the provider agreement or supplier approval date be based on the later date, i.e., the date the contractor determined that the enrollment application verification. There are other Federal requirements not related to a facility's survey, such as the provision of required Office for Civil Rights documentation and additional federal requirements specific to certain provider types, such as IPPS exclusion requirements for certain types of hospitals, capitalization and surety bond requirements for home health agencies, among others.

Accordingly, the revised rule explicitly states in §489.13(b) that:

“Federal requirements include, but are not limited to –

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

7.4 - Tie-In Notices

(Rev. 372, Issued: 03-25-11, Effective: 10-01-10, Implementation: 04-25-11)

Although it may vary by RO, tie-in and tie-out notices are generally issued in the following circumstances:

- Initial enrollment;
- CHOW;
- Acquisition/Merger;
- Consolidation;
- Addition or deletion of HHA branch, hospital unit, or OPT extension site;
- Voluntary and involuntary termination of billing numbers

As each RO may have different practices for issuing tie-in and tie-out notices, the intermediary should contact its RO to find out the specific circumstances in which such notices are issued. This also applies to instances when the RO delegates the task of issuing tie-in or tie-out notices to the State agency. The intermediary may accept such notices from the State in lieu of those from the RO. However, the intermediary should first contact the applicable RO to confirm: (1) that the latter has indeed delegated this function to the State, and (2) the specific transactions (e.g., CHOWs, HHA branch additions) for which this function has been delegated.

In addition:

- **Review for Consistency** - 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 to determine why the data is different.
- **Receipt of Tie-In When CMS-855A Not Completed** - If the contractor receives a tie-in notice from the RO but the provider never completed the necessary CMS-855A paperwork, *the contractor shall immediately contact the RO and apprise it of the situation. Then the contractor shall contact the provider and* have the provider complete and submit said paperwork. (This applies to initial applications, CHOWs, practice location additions, etc.)

Although SAs and accreditation organizations (AOs) are aware that, in accordance with Section 2003B of the State Operations Manual (SOM), they should not perform a survey of a new facility until the MAC/legacy FI/legacy carrier has provided notice that the information provided on the enrollment application has been verified and enrollment is being recommended, circumstances do occur when the sequence is reversed. When the survey occurs prior to the enrollment verification activities, we believe it is essential that the provider agreement or supplier approval date be based on the later date, i.e., the date the contractor determined that the enrollment application verification

42 CFR 489.13 governs the determination of the effective date of a Medicare provider agreement or supplier approval for health care facilities that are subject to survey and certification. §489.13 has been revised to make it clearer that the date of a Medicare provider agreement or

supplier approval may not be earlier than the latest date on which all applicable federal requirements have been met, and that such requirements include review and verification of an application to enroll in the Medicare program by CMS's legacy fiscal intermediary (FI), legacy carrier, or Medicare Administrative Contractor (MAC).

• **Creation of New L & T Record Unnecessary** - 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 a final status and can therefore be modified. Simply changing the L & T status is sufficient