CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-08 Medicare Program Integrity	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 10868	**Date: July 14, 2021**
	Change Request 12284

SUBJECT: Third General Update to Chapter 10 of Publication (Pub.) 100-08

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to -- (1) Incorporate technical, organizational, and editorial changes into parts of Chapter 10 of Pub. 100-08; and (2) Address any outstanding policy issues in the Chapter 10 sections included in this CR.

EFFECTIVE DATE: August 13, 2021
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: August 13, 2021

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	10/10.2/10.2.1/Certified Providers and Certified Suppliers That Enroll Via the Form CMS-855A
N	10/10.2/10.2.1.1/Community Mental Health Centers (CMHCs)
N	10/10.2/10.2.1.2/Comprehensive Outpatient Rehabilitation Facilities (CORFs)
N	10/10.2/10.2.1.3/End-Stage Renal Disease Facilities (ESRDs)
N	10/10.2/10.2.1.4/Federally Qualified Health Centers (FQHCs)
N	10/10.2/10.2.1.5/Histocompatibility Laboratories
N	10/10.2/10.2.1.6/Home Health Agencies (HHAs)
N	10/10.2/10.2.1.7/Hospices
N	10/10.2/10.2.1.8/Hospitals and Hospital Units
N	10/10.2/10.2.1.9/Indian Health Services (IHS) Facilities
N	10/10.2/10.2.1.10/Organ Procurement Organizations (OPOs)
N	10/10.2/10.2.1.11/Outpatient Physical Therapy/Outpatient Speech Pathology Services (OPT/OSP)
N	10/10.2/10.2.1.12/Religious Non-Medical Health Care Institutions (RNHCIs)
N	10/10.2/10.2.1.13/Rural Health Clinics (RHCs)
N	10/10.2/10.2.1.14/Skilled Nursing Facilities (SNFs)
N	10/10.2/10.2.1.15/Miscellaneous Policies
R	10/10.3/10.3.3/Other Enrollment Forms: Information and Processing
N	10/10.3/10.3.3.1/Form CMS-588 – Electronic Funds Transfer (EFT) Authorization Agreement
N	10/10.3/10.3.3.2/Form CMS-460 – Medicare Participating Physician or Supplier Agreement
R	10/10.6/10.6.4/Provider and Supplier Business Structures
R	10/10.6/10.6.7/Owning and Managing Information
N	10/10.6/10.6.7.1/Organizational Owning and Managing Information
N	10/10.6/10.6.7.2/Individual Owning and Managing Information
N	10/10.6/10.6.7.3/Owning and Managing Information – Tax Identification Numbers (TINs)
R	10/10.6/10.6.8/Billing Agencies

III. FUNDING:

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

Attachment - Business Requirements

Pub. 100-08	Transmittal: 10868	Date: July 14, 2021	Change Request: 12284

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I. GENERAL INFORMATION

A. Background: The CMS has recently completed transferring the entirety of Chapter 15 of Pub. 100-08 to Chapter 10 of Pub. 100-08. Chapter 10 outlines policies related to Medicare provider enrollment and instructs contractors on the processing of Form CMS-855 provider enrollment applications. This CR -- (1) Incorporates minor technical and editorial changes into parts of Chapter 10; and (2) Addresses several outstanding policy issues in the Chapter 10 sections included in the CR, especially those pertaining to federally qualified health centers. This CR is the third in a series of CRs that update various portions of Chapter 10 with technical revisions and any necessary policy changes.

B. Policy: This CR does not contain any legislative or regulatory policies.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
12284.1	The contractor shall enter all electronic funds transfer data into the Provider Enrollment, Chain and Ownership System.	X	X	X						
12284.2	The contractor shall be aware of the division into specific subsections of sections 10.2.1, 10.3.3, and 10.6.7 of Chapter 10 in Pub. 100-08.	X	X	X						
12284.3	The contractor shall send a copy of the approval letter to the Provider Enrollment & Oversight Group at MedicareProviderEnrollment @cms.hhs.gov in the situation described in Section	X								

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	10.2.1.4(D)(2) in Chapter 10 of Pub. 100-08.									

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

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

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: 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.

ATTACHMENTS: 0

Medicare Program Integrity Manual
Chapter 10 – Medicare Enrollment
Table of Contents
(Rev. 10868; Issued: 07-14-21)

10.2.1 – Certified Providers and Certified Suppliers That Enroll Via the Form CMS-855A

(Rev. 10868; Issued: 07-14-21; Effective: 08-13-21; Implementation: 08-13-21)

For purposes of sections 10.2.1.1 through 10.2.1.15, CMS Survey & Operations Group (SOG) Locations (formerly CMS Regional Offices) will be referenced as SOG Locations.

Sections 10.2.1.1 through 10.2.1.14 address the specific types of providers and suppliers that complete the Form CMS-855A. Section 10.2.1.15 includes certain policies pertaining to these providers and suppliers.

10.2.1.1 - Community Mental Health Centers (CMHCs)

(Rev. 10868; Issued: 07-14-21; Effective: 08-13-21; Implementation: 08-13-21)

A. General Background Information

*A CMHC is a facility that provides mental health services. A CMHC must perform certain **"core services."** These are:*

*1. **Outpatient services** (This includes services for (a) children, (b) the elderly, (c) persons who are chronically mentally ill, and (d) certain persons who have been discharged from a mental health facility for inpatient treatment.)*

*2. **24-hour**-a-day emergency psychiatric services;*

*3. **Day treatment** or other **partial hospitalization (PH) services,** or psychosocial rehabilitation services; and*

*4. **Screening** for patients being considered for admission to state mental health facilities.*

***NOTE:** Partial hospitalization is the only core service for which a CMHC can bill Medicare as a CMHC. Thus, while a facility must furnish certain "core" services in order to qualify as a CMHC, it can only get reimbursed for one of them – partial hospitalization. However, the facility may still be able to enroll in Medicare as a Part B clinic if it does not perform partial hospitalization services.*

In some instances, these core services can be furnished under arrangement. This generally means that the facility can arrange for another facility to perform the service if, among other things, CMS determines that the following conditions are met:

- *The CMHC arranging for the particular service is authorized by State law to perform the service itself;*
- *The arranging CMHC accepts full legal responsibility for the service; and*
- *There is a written agreement between the two entities*

While the CMHC generally has the option to furnish services under arrangement, there is actually an instance where the facility must do so. If the CMHC is located in a state that prohibits CMHCs from furnishing screening services (service (4) above), it must contract with another entity to have the latter perform the services. Any such arrangement must be approved by the SOG Location. (See CMS Pub. 100-07, State Operations Manual, chapter 2, section 2250 for additional information on core services and arrangements.)

A CMHC must provide mental health services principally to individuals who reside in a defined geographic area (service area); that is, it must service a distinct and definable community.

B. Initial Enrollment and Certification

1. CMHC Conditions of Participation: Federal Regulations That Apply Beginning October 29, 2014

As of October 29, 2014, CMHCs are required to meet the conditions of participation outlined in 42 CFR Part 485, subpart J. CMHCs, like many other types of certified providers and certified suppliers, are therefore required to undergo a state survey as part of the certification and enrollment process. The SOG Location no longer performs the site visit nor does the CMHC need to submit the previously-required attestation statement. Except as otherwise noted in this chapter 10 or in another CMS directive, CMHC initial applications shall – on and after October 29, 2014 - be processed in the same manner as those for all other certified providers.

2. Site Visit - Initials Post Tie-In

The contractor shall order a site visit of the CMHC through PECOS after the contractor receives the tie-in notice (or approval letter) from the SOG Location but before the contractor conveys Medicare billing privileges to the CMHC. This is to ensure that the provider is still in compliance with CMS's enrollment requirements. The scope of the site visit will be consistent with sections 10.6.20(A) and 10.6.20(B) of this chapter; the National Site Visit Contractor (NSVC) will perform the site visit. The contractor shall not convey Medicare billing privileges to the provider prior to the completion of the NSVC's site visit and the contractor's review of the results.

a. Practice Locations

Each CMHC location must separately and independently meet the CMHC conditions of participation in 42 CFR Part 485, subpart J. Accordingly, a CMHC must separately enroll each of its practice locations. It cannot have multiple locations on a single application.

If a CMHC is changing its physical location, the contractor shall order a site visit of the new/changed location through PECOS after the contractor receives notice of approval from the SOG Location but before it switches the provider's enrollment record to "Approved." This is to ensure that the new/changed location is in compliance with CMS's enrollment requirements. The scope of the site visit will be consistent with sections 10.6.20(A) and 10.6.20(B) of this chapter. The NSVC will perform the site visit. The contractor shall not switch the provider's enrollment record to "Approved" prior to the completion of the NSVC's site visit and the contractor's review of the results.

b. Revalidation Site Visits

If the CMHC submits a Form CMS-855A revalidation application, the contractor shall order a site visit through PECOS. This is to ensure that the provider is still in compliance with CMS's enrollment requirements. The scope of the site visit will be consistent with section 10.6.20 of this chapter. The NSVC will perform the site visit. The contractor shall not make a final decision regarding the revalidation application prior to the completion of the NSVC's site visit and the contractor's review of the results.

C. CMHC 40 Percent Rule

Effective October 29, 2014, under § 485.918(b)(1) a CMHC must provide at least 40 percent of its items and services to individuals who are not eligible for benefits under title XVIII of the Social Security Act; this is measured by the total number of CMHC clients treated by the CMHC for whom services are not paid for by Medicare, divided by the total number of clients treated by the CMHC in the applicable timeframe.

Pursuant to this requirement, a CMHC is required to submit to CMS a certification statement provided by an independent entity (such as an accounting technician). The document must certify that the entity has reviewed the CMHC's client care data for:

- *Initial enrollments: The CMHC meets the 40 percent requirement for the prior 3 months.*

- *Revalidations: The CMHC meets the 40 percent requirement for each of the intervening 12-month periods between initial enrollment and revalidation.*

The statement must be submitted as part of any initial enrollment or revalidation (including off-cycle revalidations).

When processing the application, the contractor shall abide by the following:

1. Contractor Does Not Receive the Certification

If the contractor does not receive the certification with the Form CMS-855, the contractor shall develop for the certification as it would with any other form of required supporting documentation. If the CMHC fails to submit the certification within the applicable time period, the contractor shall follow the instructions in section 10.4(H)(2) of this chapter.

2. Contractor Receives the Certification

If the contractor receives the certification with the Form CMS-855 or timely receives the certification as part of a development request, the contractor shall review the certification to ensure that it complies with § 485.918(b)(1) and the provisions of this section 10.2.1.1(C). If the certification is compliant, the contractor shall continue processing the application; if the certification is not compliant, the contractor shall deny the application or, if it chooses, develop for a revised certification.

Section 10.2.1.1(C) does not apply if the contractor determines that the Form CMS-855 can be returned under section 10.4(H)(1) of this chapter.

If the contractor exceeds applicable timeliness standards due to the instructions in this section 10.2.1.1(C), the contractor shall accordingly document the provider file consistent with section 10.6.19(H) of this chapter.

3. Special Guidelines

The following additional guidelines concerning certification apply:

(i) As previously indicated, an appropriate official of the certifying entity must sign the document. (Notarization is not required unless CMS requests it.) Such persons may include accounting technicians, CEOs, officers, directors, etc.

(ii) The certification should be on the certifying entity's letterhead or should otherwise indicate that the document is clearly from the entity.

(iii) The contractor shall include the certification in the recommendation package it sends to the state agency.

Unless CMS instructs the contractor otherwise, the appropriate denial bases for failing to comply with § 485.918(b)(1) are §§ 424.530(a)(1) and 485.918(b)(1). The appropriate revocation bases are §§ 424.535(a)(1) and 485.918(b)(1). In cases involving the latter, CMS will determine the appropriate re-enrollment bar length under § 424.535(c) and will notify the contractor thereof.

D. For more information on CMHCs, refer to:

- *Section 1861(ff) of the Social Security Act*
- *42 CFR §§ 410.2, 410.43, and 410.110*
- *Pub. 100-07, chapter 2, sections 2250 - 2251F*

10.2.1.2 - Comprehensive Outpatient Rehabilitation Facilities (CORFs)

(Rev. 10868; Issued: 07-14-21; Effective: 08-13-21; Implementation: 08-13-21)

A. General Background Information

A CORF is a facility established and operated at a single fixed location exclusively for the purpose of providing diagnostic, therapeutic, and restorative services to outpatients by or under the supervision of a physician. Specific examples of such services include:

- *Physician services (*)*
- *Physical therapy (*)*
- *Occupational therapy*
- *Respiratory therapy*
- *Speech pathology*
- *Social work or psychological services (*)*
- *Prosthetic/orthotic devices*
- *Lab services (must meet 42 CFR Part 493 requirements)*

(Services that the CORF must provide)*

In addition:

- *If the SOG Location determines that sufficient functional and operational independence exists, a CORF may be able to share space with another Medicare provider. However, the CORF may not operate in the same space at the same time with another Medicare provider. (See Pub. 100-07, chapter 2, sections 2364 - 2364C for more information.)*

- *Like most certified providers, CORFs must be surveyed by the state agency and must sign a provider agreement.*

- *On occasion, an outpatient physical therapy/speech language pathology location might convert to a CORF; prior to enrolling in Medicare, however, it must be surveyed to ensure that the CORF conditions of participation are met.*

B. Enrollment Information

1. Offsite Locations

Notwithstanding the "single fixed location" language cited in section 10.2.1.2(A) above, there may be isolated cases where the SOG Location permits a CORF to have an offsite location. This typically arises if the CORF wants to provide physical therapy, occupational therapy, or speech language pathology services away from the primary location. (This is permitted under 42 CFR § 485.58(e)(2)). The offsite location would not necessarily be separately surveyed but would be listed as a practice location on the CORF's Form CMS-855A application.

2. Site Visits

a. Initial application – If a CORF submits an initial application, the contractor shall order a site visit through PECOS after the contractor receives the tie-in notice (or approval letter) from the SOG Location but before the contractor conveys Medicare billing privileges to the CORF. This is to ensure that the provider is still in compliance with CMS's enrollment requirements. The scope of the site visit will be consistent with sections 10.6.20(A) and 10.6.20(B) of this chapter. The NSVC will perform the site visit. The contractor shall not convey Medicare billing privileges to the provider prior to the completion of the NSVC's site visit and the contractor's review of the results.

b. Revalidation – If a CORF submits a revalidation application, the contractor shall order a site visit through PECOS. This is to ensure that the provider is still in compliance with CMS's enrollment requirements. The scope of the site visit will be consistent with sections 10.6.20(A) and 10.6.20(B) of this chapter. The NSVC will perform the site visit. The contractor shall not make a final decision regarding the revalidation application prior to the completion of the NSVC's site visit and the contractor's review of the results.

c. New/changed location - If a CORF is (1) adding a new location or (2) changing the physical location of an existing location, the contractor shall order a site visit of the new/changed location through PECOS after the contractor receives notice of approval from the SOG Location, but before the contractor switches the provider's enrollment record to "Approved." This is to ensure that the new/changed location is in compliance with CMS's enrollment requirements. The scope of the site visit will be consistent with sections 10.6.20(A) and 10.6.20(B) of this chapter. The NSVC will perform the site visit. The contractor shall not make a final decision regarding the change of information application prior to the completion of the NSVC's site visit and the contractor's review of the results.

C. Additional Information

For more information on CORFs, refer to:

- *Section 1861(cc) of the Social Security Act*
- *42 CFR Part 485, Subpart B*
- *Pub. 100-07, chapter 2*
- *Pub. 100-07, Appendix K*
- *Pub. 100-02, Benefit Policy Manual, chapter 12*

10.2.1.3 - End-Stage Renal Disease Facilities (ESRDs)

(Rev. 10868; Issued: 07-14-21; Effective: 08-13-21; Implementation: 08-13-21)

A. General Background Information

ESRD facilities are entities that provide renal services and related care for patients with irreversible and permanent kidney failure. As ESRD facilities are technically "suppliers," they sign a supplier agreement rather than a provider agreement. Even if the ESRD facility is a hospital unit, it signs an agreement that is separate and distinct from the hospital's agreement. ESRD entities/facilities cannot be mobile.

The provider-based rules for ESRD facilities are outlined in 42 CFR § 413.174 and are slightly different than those in the main provider-based regulation (42 CFR § 413.65). (For instance, § 413.174 uses the term "hospital-based" as opposed to "provider-based.")

The ESRD Network is a group of organizations under contract with CMS that serve as liaisons between the agency and ESRD providers. The organizations oversee the care that ESRD patients receive, collect data, and furnish technical assistance to ESRD providers and patients.

B. Types of ESRD Facilities

Pub. 100-07, chapter 2, section 2272 lists several classifications of ESRD facilities. They are summarized as follows:

1. Hospital-Based ESRD Facility

A hospital-based ESRD facility is a separately certified ESRD facility that (1) is an outpatient department of a hospital and (2) meets the ESRD conditions of coverage at 42 CFR Part 494. A hospital-based ESRD facility is owned and administered by a hospital or critical access hospital and is physically located on the hospital campus. If a hospital operates multiple separately certified hospital-based ESRD facilities, each separate ESRD facility must have its own CCN and be separately enrolled.

A hospital-based ESRD facility is discussed at 42 CFR § 413.174(c) and meets the criteria listed therein (e.g., ESRD facility and hospital have a common governing body and are financially integrated). Hospital-based ESRD facilities are assigned CCNs from the 2300-2499 series.

2. Satellite Renal Dialysis Facility (Hospital-Based)

A satellite renal dialysis facility is a hospital-owned and hospital-administered ESRD facility but is not located on the campus of the hospital. A single hospital may have several satellite renal dialysis facilities. Each satellite facility: (1) is separately certified and surveyed; (2) must independently meet the ESRD conditions of coverage; (3) is assigned its own CCN; and (4) be separately enrolled. Satellite renal dialysis facilities (hospital-based) are assigned CCNs in the 3500-3699 series.

3. Independent Renal Dialysis Facility

An independent renal dialysis facility is any ESRD facility that does not meet the definition of a hospital-based renal dialysis facility or satellite renal dialysis facility as described in the paragraphs above. An independent renal dialysis facility may be physically located on a hospital campus, but it is not owned and/or administered by the hospital. Independent renal dialysis facilities are assigned CCNs in the 2500-2899 series and are individually enrolled.

4. Special Purpose Renal Dialysis Facility (SPRDF) (§ 494.120)

This type of renal disease facility is temporarily certified to furnish dialysis at special locations on a short-term basis (i.e., up to 8 months in any 12 month period) to a group of dialysis patients who would otherwise be unable to obtain treatment in the geographical area. The SOG Location must clearly specify the limited nature of the SPRDF certification, the time period covered by the certification, and the automatic termination of payment on the last day of the certification period in its notifications. The special locations for SPRDF fall into two categories:

(A) Vacation Camps - Vacation camps serve dialysis patients temporarily residing there. A vacation camp SPRDF would allow campers to receive hemodialysis at the camp site, avoiding interruption of the camping experience. Vacation camps may be approved for the duration of the camp but up to a maximum of 8 months in any 12-month period.

(B) Emergency Circumstance SPRDFs - These locations are set up to provide dialysis services to those ESRD patients who would otherwise be unable to obtain such services in their geographical area as a result of a natural or man-made disaster or a need for a greater capacity to dialyze patients who may have been evacuated from another location. The CMS SOG Location may extend the time period in emergency SPRDF approvals, where necessary, beyond the standard eight-month period based upon the termination of the emergency condition.

SPRDFs are assigned CCNs in the 3700-3799 series when owned and administered by a hospital and in the 2900-2999 series for independent facilities; they are individually enrolled.

C. ESRD Enrollment

An ESRD facility is separately and individually certified and does not have any branch, multiple, or parent locations. As such, each type of ESRD facility/location must independently and separately enroll as such via the Form CMS-855A; multiple sites cannot be listed on a single application.

The Form CMS-855A does not distinguish between the different types of ESRD facilities. If an enrolled ESRD facility wants to change to another type of ESRD facility or expand/add ESRD stations, the provider therefore need not submit a Form CMS-855A change of information (e.g., an ESRD station does not qualify as a practice location on the Form CMS-855A). However, the SOG Location may issue a tie-in notice or approval letter to the contractor as notification of the change. Also, the ESRD facility shall contact the state and the SOG Location to see if it must submit other documents or undergo other reviews pursuant to the change in ESRD type.

D. ESRD Survey and Certification

The standard CMS survey and certification form used for ESRDs is the Form CMS-3427. For more information on this form, see Pub. 100-07, chapter 2, section 2247B.

E. Site Visits

Site visits for ESRDs are performed during the survey and certification process by the state agency.

For further information on ESRD facilities, refer to:

- *Section § 1881 of the Social Security Act*
- *42 CFR Part 405, Subpart U*
- *Pub. 100-07, chapter 2, section 2270 – 2287B*
- *Pub. 100-02, chapter 11*
- *Pub. 100-04, Claims Processing Manual, chapter 8*

10.2.1.4 - Federally Qualified Health Centers (FQHCs)
(Rev. 10868; Issued: 07-14-21; Effective: 08-13-21; Implementation: 08-13-21)

A. Statutory Background

Section 4161(a)(2) of OBRA '90 (P.L. 101-508) amended §1861(aa) of the Act and established FQHC services as a benefit under the Medicare program effective October 1, 1991. The statutory requirements that entities must meet to be considered an FQHC for Medicare purposes are at §1861(aa)(4) of the Act. Regulations establishing the FQHC benefit and outlining the Conditions for Coverage for FQHCs were published on June 12, 1992, in the Federal Register (57 FR 24961) and became effective on the date of publication. These regulations were amended on April 3, 1996 (61 FR 14640). Section 13556 of OBRA 1993 (P.L. 103-66) amended §1861(aa) of the Act by adding outpatient health programs or facilities operated by a tribe or tribal organization under the Indian Self-Determination Act or by an urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act, as entities eligible to participate in Medicare as FQHCs.

B. Requirements

FQHCs furnish services such as those performed by physicians, nurse practitioners, physician assistants, clinical psychologists, certified nurse-midwives, and clinical social workers. This also includes certain preventive services like prenatal services, immunizations, blood pressure checks, hearing screenings and cholesterol screenings. (See Pub. 100-02, chapter 13 for more information). To participate in the Medicare program, applicants seeking initial enrollment as an FQHC must submit a Form CMS-855A application to the appropriate Medicare Administrative Contractor (MAC). Even though they complete the Form CMS-855A application, FQHCs are considered Part B certified suppliers and are paid Part B benefits for FQHC services.

FQHCs are not required to obtain a state survey. However, FQHCs still must meet all applicable state and local requirements and submit all applicable licenses. Typically, the Health Resources and Services Administration (HRSA) will verify such state/local compliance by asking the FQHC to attest that it meets all state/local laws.

FQHCs can be located in a rural or urban area that is designated as either a health professional shortage area or an area that has a medically underserved population.

For purposes of Medicare enrollment, an FQHC is defined as an entity that has entered into an agreement with CMS to meet Medicare program requirements under 42 CFR § 405.2434(a), and (as outlined in Pub. 100-07, chapter 9, exhibit 179):

- *Is receiving a grant under § 330 of the Public Health Service (PHS) Act;*

- *Is receiving funding under a contract with the recipient of a § 330 grant, and meets the requirements to receive a grant under § 330 of the PHS Act;*
- *Is an FQHC "Look-Alike" (i.e., HRSA), has notified it that it meets the requirements for receiving a § 330 grant, even though it is not actually receiving such a grant);*
- *Was treated by CMS as a comprehensive federally funded health center as of January 1, 1990; or*
- *Is an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act or by an Urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act.*

C. Initial FQHC Applications

1. Contractor Review and Required Documents

In contrast to both past practice and the process that is normally followed with other certified provider/certified supplier types, the contractor does not make a recommendation for approval to the state/SOG Location for FQHC applications. Instead, the contractor will either approve or deny the application at the contractor level pursuant to the instructions in this section.

The following documents must be included with the FQHC's completed Form CMS-855A application:

- *One signed and dated copy of the attestation statement (Exhibit 177). In order to attest to being in compliance, the facility must be open and operating when the attestation is signed. Since FQHCs must sign an agreement stipulating that they will comply with § 1861(aa)(4) of the Act and specific FQHC regulations, this statement serves as the Medicare FQHC benefit (or provider/supplier) agreement when it is also signed and dated by PEOG. (See Pub. 100-07, chapter 2, section 2826B.)*

- *HRSA Notice of Grant Award or FQHC Look-Alike Designation that includes an address for the site of the applicant which matches the practice location reported on the Form CMS-855A. A Notice of Grant Award by HRSA verifies that the applicant qualifies as a FQHC grant recipient; the FQHC Look-Alike Designation Memo from HRSA verifies look-alike status.*

- *Form CMS-588; Electronic Funds Transfer (EFT) Authorization Agreement.*

- *Clinical Laboratory Improvement Act (CLIA) Certificate (if applicable). Facilities that examine human specimens for the diagnosis, prevention, or treatment of any disease or impairment of, or the assessment of the health of, human beings is considered a laboratory and must meet CLIA requirements. These facilities must apply and obtain a certificate from the CLIA program that corresponds to the complexity of tests performed. Certain types of laboratories and laboratory tests are NOT subject to meeting CLIA requirements. One example would be facilities which serve only as collection stations. A collection station receives specimens to be forwarded to a laboratory performing diagnostics test. Pub. 100-07, chapter 6, section 6002 provides additional details regarding laboratories and laboratory tests NOT subject to CLIA requirements. It is the FQHC's responsibility to review the CLIA requirements and obtain a CLIA certificate if needed. Neither the contractor nor CMS determines whether the FQHC needs to obtain and submit a CLIA certificate.*

- *Copy of state license (if applicable).*

2. General Processing Concepts

(A) Practice Locations - An FQHC cannot have multiple sites or practice locations. Each location must be separately enrolled and will receive its own CCN.

(B) Name on Exhibit 177 - The contractor shall ensure that Exhibit 177 contains the same legal business name and address as that which the FQHC provided in Section 2 and Section 4, respectively, of the Form CMS-855A. If the attestation contains a different name, the contractor shall develop for the correct name.

(C) Date on Exhibit 177 - The contractor shall ensure that the date on which the Exhibit 177 was signed is on or after the date the FQHC listed as its effective date on the Form CMS-855A application. If the Exhibit 177 was signed prior to the listed effective date, the contractor shall follow the instructions in section 10.2.1.4(C)(3)(b) below; the FQHC should be providing services in order to meet the regulations noted in Exhibit 177.

(D) Date Application Complete - When reviewing an initial FQHC application, the contractor shall verify the date on which the FQHC's application was complete. To illustrate, assume that the FQHC submitted an initial application on March 1. Two data elements were missing, so the contractor requested additional information. The two elements were submitted on March 30. The contractor shall therefore indicate the March 30 date in its approval letter as the effective date of the FQHC.

(E) Site Visits - Site visits for FQHCs are performed by HRSA prior to enrollment.

(F) Contractor Jurisdiction - Except for tribal and Urban Indian FQHCs, a freestanding FQHC that is initially enrolling is assigned to the Medicare Administrative Contractor (MAC) that covers the state in which the FQHC is located. An initially enrolling tribal or Urban Indian FQHC is assigned to the Jurisdiction H MAC.

(G) Tribal/Urban Indian Organizations – Certain outpatient health programs or facilities may be operated by a tribe or tribal organization or by an Urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act. The contractor shall confirm the applicant's attestation and tribal/urban Indian status if the FQHC indicates on the application that it has such status; several means are available:

- *The applicable Indian Health Service (IHS) web link at https://www.ihs.gov/locations/. The contractor can search for the facility by clicking on the "Find Health Care" sub-link https://www.ihs.gov/findhealthcare/?CFID=15011511&CFTOKEN=36378825 or downloading the Excel complete listing of HIS facilities. (These are the highly recommended means of verification.)*

- *Contacting (1) the IHS directly, (2) contacting the applicable SOG Location, or (3) the contractor's PEOG BFL.*

(H) Potential RHC Relationship – On occasion, a rural health clinic (RHC) may seek to convert to an FQHC. (A facility cannot be both an RHC and an FQHC.)

Accordingly, in its review of an initial FQHC application, the contractor shall check PECOS to determine whether an RHC is enrolled at the same location. If one is, the contractor shall refer the matter to MedicareProviderEnrollment@cms.hhs.gov. In doing so, the contractor shall furnish to PEOG (1) the names, NPIs, and shared address of the RHC and FQHC, and (2) a copy of all information submitted with the FQHC application; the e-mail's subject line shall state: "RHC & FQHC shared address".

3. Determination

a. Approval

The contractor shall contact PEOG via email at MedicareProviderEnrollment@cms.hhs.gov if it believes that the FQHC's initial application should be approved. The contractor shall provide to PEOG: (1) a copy of the draft approval letter (see section 10.7.19 of this chapter for a model FQHC approval letter); (2) the Form CMS-855A application or PECOS Application Data Report (ADR) and all supporting documentation; (3) a copy of the FQHC's HRSA documentation; and (4) Exhibit 177.

While awaiting PEOG's final determination---and beginning on the date following the sending of the aforementioned e-mail---the application processing time clock is stopped. It resumes on the date on which the contractor receives PEOG's decision. Communication between the contractor and PEOG during this "waiting period" (e.g., PEOG request for additional information from the contractor) does not restart the clock.

b. Denial

If the contractor believes that the FQHC's application should be denied, the contractor shall notify the applicant of the denial using the appropriate model letter guidance in section 10.7.8 of this chapter. If the contractor is uncertain as to whether a denial is warranted or what the appropriate denial ground under 42 CFR 424.530(a) should be, it may contact its PEOG BFL for guidance.

4. Post-PEOG Review and Response to Contractor

If PEOG determines (based on the information the contractor furnished) that the FQHC's application should be approved, PEOG will:

- *Assign the CCN, which will be part of the 1800-1989 series*
- *Assign the effective date, which will be the date the FQHC application was considered complete by the contractor*
- *Make any necessary revisions to the draft approval letter*
- *Sign and date the attestation using the completion date, which is also the effective date (Exhibit 177)*
- *E-mail all of the foregoing documents and data to the contractor, at which point the aforementioned processing time clock resumes.*

5. Post-Approval Contractor Action

If PEOG notifies the contractor that the FQHC's application should be approved, the contractor shall send the approval letter to the FQHC with a copy of the signed Exhibit 177.

D. Location Changes

1. Verification

If an FQHC is changing the physical location of an existing site, the FQHC must submit the following documentation (as applicable to that FQHC) to the contractor:

- *For § 330 grantees, a Notice of Grant Award approving the physical location change and the new address; or*
- *For look-alikes, an updated letter from HRSA approving the physical location change and listing the new address.*

(Consistent with the instructions in this chapter, the contractor shall develop for this documentation with the FQHC if the latter fails to submit it.)

For tribal/Urban Indian organizations, the contractor may confirm the new location via the IHS website or by contacting IHS. (See section 10.2.1.4(C)(2)(G) above for the web link.)

In all cases, the new address listed on the notice of grant award, IHS website, etc., must match that listed on the Form CMS-855A change request. If it does not, the contractor shall develop with the FQHC for clarification consistent with the instructions in this chapter.

2. Approval

If approving the location change, the contractor does not issue a recommendation of approval to the SOG Location, notwithstanding any instruction to the contrary in this chapter; rather, the contractor shall approve the location change in PECOS and issue an approval letter to the FQHC (with an e-mailed copy to PEOG at MedicareProviderEnrollment@cms.hhs.gov; PEOG will update ASPEN accordingly). Beginning on March 15, 2021, tie-in notices will not be issued for address changes.

3. Denial

If the contractor does not approve the location change (i.e., the FQHC is no longer located in a shortage area, the FQHC fails to submit the applicable HRSA supporting documentation after contractor development (discussed above), or another reason is implicated), the contractor shall refer the matter to PEOG at ProviderEnrollmentRevocations@cms.hhs.gov consistent with all applicable instructions in this chapter and other CMS directives. (The referral shall include, at a minimum, the FQHC's LBN and NPI as well as a brief explanation of the situation and the reason for referral.) PEOG will review the matter and instruct the contractor on how to proceed.

While awaiting PEOG's final determination---and beginning on the date following the sending of the aforementioned e-mail---the application processing time clock is stopped. It resumes on the date on which the contractor receives PEOG's decision. Communication between the contractor and PEOG during this "waiting period" (e.g., PEOG request for additional information from the contractor) does not restart the clock.

E. Revocations and Other Transactions

Except as otherwise stated or required by CMS, the contractor shall continue to adhere to the applicable instructions in this chapter and all other CMS directives regarding:

- *Potential FQHC revocations and referrals (including sending the referral/information to the appropriate PEOG mailbox)*
- *Changes of ownership*
- *Changes of information*
- *Revalidations*
- *Reactivations*

Upon revalidation or reactivation, an FQHC need not submit a new HRSA Notice of Award (NoA) (unless HRSA made an update and issued the FQHC a new one) or new Exhibit 177; new provider agreements are not required for either transaction.

F. Complaint Investigations

CMS SOG Locations investigate complaints that raise credible allegations of an FQHC's noncompliance with health and safety standards found at 42 CFR 405 Subpart X, and 42 CFR 491 Subpart A (except for 42 CFR § 491.3). The contractor shall refer such complaints to the SOG Location that has jurisdiction over the FQHC.

For additional general information on FQHCs, refer to:

- *Section 1861(aa)(3-4) of the Social Security Act*
- *42 CFR Part 491 and 42 CFR Part 405, subpart X*
- *Pub. 100-07, chapter 2, sections 2825 – 2826H*
- *Pub. 100-07, chapter 9, exhibits 177 and 179*
- *Admin Info 21 06-ALL – Transitioning FQHC Certification Enrollment Performed by the CMS SOG (Standard Operating Procedures attached)*
- *Pub. 100-04, chapter 9*
- *Pub. 100-02, chapter 13*

For additional information on the appropriate contractor jurisdictions for incoming FQHC enrollment applications, see Pub. 100-04, chapter 1, section 20 as well as Pub. 100-07, chapter 9, exhibit 179.

10.2.1.5 - Histocompatibility Laboratories

(Rev. 10868; Issued: 07-14-21; Effective: 08-13-21; Implementation: 08-13-21)

A histocompatibility laboratory does "matching" tests in preparation for procedures such as kidney transplants, bone marrow transplants, and blood platelet transfusions. It is the only type of laboratory that must submit a Form CMS-855A application. Each histocompatibility lab must meet all applicable requirements in 42 CFR Part 493 (see 42 CFR § 493.1 in particular) and undergo a state survey.
For information on the appropriate contractor jurisdiction for incoming histocompatibility lab applications, see Pub. 100-04, chapter 1, section 20.

10.2.1.6 - Home Health Agencies (HHAs)

(Rev. 10868; Issued: 07-14-21; Effective: 08-13-21; Implementation: 08-13-21)

A. General Background Information

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

Like most certified providers, HHAs receive a state survey (or a survey from an approved accrediting organization) to determine compliance with federal, state, and local laws) and must sign a provider agreement.

B. Site Visit Requirements

See sections 10.6.20(A) and 10.6.20(B) of this chapter for more information on HHA site visit requirements.

C. HHA Components

There are two potential "components" of an HHA organization:

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

Branch – A branch office 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 office 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 on a daily basis. The branch office is not required to independently meet the conditions of participation as an HHA; the branch can thus be listed as practice locations on the main provider's Form CMS-855A. Though the branch receives a 10-digit CCN identifier, it bills under the parent HHA's CCN.

See Pub. 100-07, chapter 2 for more information on branches.

D. Out-of-State HHA Operations

Pub. 100-07, chapter 2, section 2184 states that when an HHA provides services across state lines:

- *It must be certified by the state in which its CCN is based.*
- *The involved states must have a written reciprocal agreement permitting the HHA to provide services in this manner. In those states that have a reciprocal agreement, HHAs are not required to be separately approved in each state; consequently, they would not have to obtain a separate Medicare provider agreement/number in each state. HHAs residing in a state that does not have a written reciprocal survey agreement with a contiguous state are precluded from providing services across state lines; the HHA must establish a separate parent agency in the state in which it wishes to provide services.*
- *A CMS approved branch office may be physically located in a neighboring state if the state agencies responsible for certification in each state approve the operation.*

See section 10.3.1(A)(1)(d)(iii) of this chapter for additional information regarding the enrollment of out-of-state HHA locations.

E. Verification of HHA Sites

HHAs are not permitted to share a practice location address. If the contractor receives an application from an HHA that has the same general practice location address as another enrolled (or enrolling) HHA and the contractor has reason to suspect that the HHAs may be concurrently operating out of the same suite or office, the contractor shall notify the NSVC of this at the time the contractor orders the required site visit through PECOS. If the site visit uncovers two HHAs operating within the same practice location address, the contractor shall deny/reject the application for enrollment.

F. Nursing Registries

If the HHA checks "yes" in Section 12B of the Form CMS-855A, the contractor shall ensure that the information furnished about the HHA nursing registry is accurate. (A nursing registry is akin to a staffing agency, whereby a private company furnishes nursing personnel to hospitals, clinics, and other medical providers.)

G. HHA Ownership Changes

1. Background

Effective January 1, 2011, and in accordance with 42 CFR § 424.550(b)(1), if there is a change in majority ownership of an HHA by sale (including asset sales, stock transfers, mergers, and consolidations) within 36 months after the effective date of the HHA's initial enrollment in Medicare or within 36 months after the HHA's most recent change in majority ownership, the provider agreement and Medicare billing privileges do not convey to the new owner. The prospective provider/owner of the HHA must instead:

- *Enroll in the Medicare program as a new (initial) HHA under the provisions of § 424.510, and*
- *Obtain a state survey or an accreditation from an approved accreditation organization.*

For purposes of § 424.550(b)(1), a "change in majority ownership" (as defined in 42 CFR § 424.502) occurs when an individual or organization acquires more than a 50 percent direct ownership interest in an HHA during the 36 months following the HHA's initial enrollment into the Medicare program or the 36 months following the HHA's most recent change in majority ownership (including asset sales, stock transfers, mergers, or consolidations). This includes an individual or organization that acquires majority ownership in an HHA through the cumulative effect of asset sales, stock transfers, consolidations, or mergers during the 36-month period after Medicare billing privileges are conveyed or the 36-month period following the HHA's most recent change in majority ownership.

2. Exceptions

There are several exceptions to § 424.550(b)(1). Specifically, the requirements of § 424.550(b)(1) do not apply if:

- *The HHA has submitted 2 consecutive years of full cost reports. (For purposes of this exception, low utilization or no utilization cost reports do not quality as full cost reports.)*

- *The HHA's parent company is undergoing an internal corporate restructuring, such as a merger or consolidation.*

- *The HHA is changing its existing business structure – such as from a corporation, a partnership (general or limited), or a limited liability company (LLC) to a corporation, a partnership (general or limited) or an LLC - and the owners remain the same.*

- *An individual owner of the HHA dies.*

In addition, § 424.550(b)(1) does not apply to "indirect" ownership changes.

3. Timing of 36-Month Period

As indicated earlier, the provisions of 42 CFR § 424.550(b)(1) and (2) (as enacted in "CMS-6010-F, Medicare Program; Home Health Prospective Payment System Rate Update for Calendar Year 2011; Changes in Certification Requirements for Home Health Agencies and Hospices; Final Rule") became effective January 1, 2011. This means these provisions impact only those HHA ownership transactions whose effective date is on or after January 1, 2011. However, the provisions can apply irrespective of when the HHA first enrolled in Medicare. Consider the following illustrations:

- *Example 1 – Smith HHA initially enrolled in Medicare effective July 1, 2009. Smith underwent a change in majority ownership effective September 1, 2011. The provisions of § 424.550(b)(1) applied to Smith because it underwent a change in majority ownership within 36 months of its initial enrollment.*

- *Example 2 – Jones HHA initially enrolled in Medicare effective July 1, 2007. Jones underwent a change in majority ownership effective February 1, 2019. Section 424.550(b)(1) did not apply to this transaction because it occurred more than 36 months after Jones's initial enrollment. Suppose, however, that Jones underwent another change in majority ownership effective February 1, 2020. Section 424.550(b)(1) applied to this transaction because it took place within 36 months after Jones's most recent change in majority ownership (i.e., on February 1, 2019).*

- *Example 3 – Davis HHA initially enrolled in Medicare effective July 1, 2012. It underwent its first change in majority ownership effective December 1, 2015. This change was not affected by §424.550(b)(1) because it occurred more than 36 months after Davis's initial enrollment. Davis underwent another change in majority ownership effective July 1, 2019. This change, too, was unaffected by § 424.550(b)(1), for it occurred more than 36 months after the HHA's most recent change in majority ownership (i.e., on December 1, 2015). Davis underwent another majority ownership change on July 1, 2020. This change was impacted by § 424.550(b)(1), since it occurred within 36 months of the HHA's most recent change in majority ownership (i.e., on July 1, 2019).*

4. Determining the 36-Month Rule's Applicability

If the contractor receives a Form CMS-855A application reporting an HHA ownership change (and unless a CMS instruction or directive states otherwise), it shall undertake the following steps:

Step 1 – Change in Majority Ownership

The contractor shall determine whether a change in direct majority ownership has occurred. Through its review of the transfer agreement, sales agreement, bill of sale, etc., the contractor shall verify whether:

- *The ownership change was a direct ownership change and not a mere indirect ownership change, and*

- *The change involves a party assuming a greater than 50 percent ownership interest in the HHA.*

Assumption of a greater than 50 percent direct ownership interest can generally occur in one of three ways. First, an outside party that is currently not an owner can purchase more than 50 percent of the business in a single transaction. Second, an existing owner can purchase an additional interest that brings its total ownership stake in the business to greater than 50 percent. For instance, if a 40 percent owner purchased an additional 15 percent share of the HHA, this would constitute a change in majority ownership. This is consistent with the verbiage in the aforementioned definition of "change in majority ownership" regarding the "cumulative effect" of asset sales, transfers, etc. Another example of a change in majority ownership would be if a 50 percent owner obtains any additional amount of ownership (regardless of the percentage) and hence becomes a majority owner; thus, for instance, if a 50 percent owner were to acquire an additional .001 percent ownership stake, he or she becomes a majority owner and the transaction involves a change in majority ownership.

If the transfer does not qualify as a change in majority ownership, the contractor can process the application normally (which will typically be as a change of information under 42 CFR § 424.516(e)). If it does qualify, the contractor shall proceed to Step 2:

Step 2 – 36-Month Period

The contractor shall determine whether the effective date of the transfer is within 36 months after the effective date of the HHA's (1) initial enrollment in Medicare or (2) most recent change in majority ownership. The contractor shall verify the effective date of the reported transfer by reviewing a copy of the transfer agreement, sales agreement, bill of sale, etc., rather than relying upon the date of the sale as listed on the application. It shall also review its records – and, if necessary, request additional information from the HHA – regarding the effective date of the HHA's most recent change in majority ownership, if applicable.

If the effective date of the transfer does not fall within either of the aforementioned 36-month periods, the contractor may process the application normally; specifically, the contractor shall, as applicable and depending upon the facts of the case, process the application as a change of information under 42 CFR § 424.516(e) or as a potential change of ownership under 42 CFR § 489.18.

If the transfer's effective date falls within one of these 36-month timeframes, the contractor shall proceed to Step 3.

Step 3 – Applicability of Exceptions

If the contractor determines that a change in majority ownership has occurred within either of the above-mentioned 36-month periods, the contractor shall determine whether any of the exceptions in § 424.550(b)(2) apply. As alluded to earlier, the exceptions are as follows:

i. The HHA has submitted 2 consecutive years of full cost reports.

(A) For purposes of this exception, low utilization or no utilization cost reports do not qualify as full cost reports. (See 42 CFR § 413.24(h) for a definition of low Medicare utilization.)

(B) The cost reports must have been: (1) consecutive, meaning that they were submitted in each of the 2 years preceding the effective date of the transfer; and (2) accepted by the contractor.

ii. The HHA's parent company is undergoing an internal corporate restructuring, such as a merger or consolidation.

iii. The HHA is changing its existing business structure – such as from a corporation, a partnership (general or limited), or an LLC to a corporation, a partnership (general or limited) or an LLC - and the owners remain the same.

(A) If the HHA is undergoing a change in business structure other than those which are specifically mentioned in this exemption (e.g., corporation to an LLC), the contractor shall contact its PEOG Business Function Lead (BFL) for guidance.

(B) For the exemption to apply, the owners must remain the same.

iv. An individual owner of the HHA dies – regardless of the percentage of ownership the person had in the HHA.

5. Determination

If the contractor concludes that one of the aforementioned exceptions applies (and unless a CMS instruction or directive states otherwise), it may process the application normally; specifically, the contractor shall, as applicable and depending upon the facts of the case, process the application as a change of information under 42 CFR § 424.516(e) or as a potential change of ownership under 42 CFR § 489.18.

If no exception applies, the contractor shall refer the case to its PEOG BFL for review. Under no circumstances shall the contractor apply the 36-month rule to the HHA and require an initial enrollment based thereon without the prior approval of PEOG. If PEOG agrees with the contractor's determination, the contractor shall send a letter to the HHA notifying it that, as a result of § 424.550(b)(1), the HHA must:

- *Enroll as an initial applicant; and*

- *Obtain a new state survey or accreditation survey after it has submitted its initial enrollment application and the contractor has made a recommendation for approval to the state/SOG Location.*

As the new owner must enroll as a new provider, the contractor shall also deactivate the HHA's billing privileges if the sale has already occurred. The effective date of the deactivation shall be the date the HHA is notified that it must enroll as an initial applicant. If the sale has not occurred, the contractor shall alert the HHA that it must submit a Form CMS-855A voluntary termination application.

Providers and/or their representatives (e.g., attorneys, consultants) shall contact their local MAC with any questions concerning (1) the 36-month rule in general and (2) whether the rule and/or its exceptions apply in a particular provider's case.

6. Additional Notes

The contractor is advised of the following:

i. *If the contractor learns of an HHA ownership change by means other than the submission of a Form CMS-855A application, it shall notify its PEOG BFL immediately.*

ii. *If the contractor determines, under Step 3 above, that one of the § 424.550(b)(2) exceptions applies, the ownership transfer still qualifies as a change in majority ownership for purposes of the 36-month clock. To illustrate, assume that an HHA initially enrolled in Medicare effective July 1, 2010. It underwent a change in majority ownership effective February 1, 2012. The contractor determined that the transaction was exempt from § 424.550(b)(1) because the HHA submitted full cost reports in the previous 2 years. On February 1, 2014, the HHA underwent another change in majority ownership that did not qualify for an exception. The HHA thus had to enroll as a new HHA under § 424.550(b)(1) because the transaction occurred within 36 months of the HHA's most recent change in majority ownership - even though the February 2012 change was exempt from § 424.550(b)(1).*

H. Capitalization

1. Background

Effective January 1, 2011, and pursuant to 42 CFR §§ 489.28(a) and 424.510(d)(9), an HHA entering the Medicare program - including a new HHA resulting from a change of ownership if the change of ownership results in a new provider number being issued - must have available sufficient funds (known as initial reserve operating funds) at (1) the time of application submission and (2) all times during the enrollment process, to operate the HHA for the three-month period after the Medicare contractor conveys billing privileges (exclusive of actual or projected accounts receivable from Medicare). This means that the HHA must also have available sufficient initial reserve operating funds during the 3-month period following the conveyance of Medicare billing privileges.

2. Points of Review

At a minimum, the contractor shall verify that the HHA meets the required amount of capitalization:

- *Prior to making its recommendation for approval;*
- *After a recommendation for approval is made but before the SOG Location review process is completed;*
- *After the SOG Location review process is completed but before the contractor conveys Medicare billing privileges to the HHA; and*
- *During the 3-month period after the contractor conveys Medicare billing privileges to the HHA*

For initial applications, the contractor shall verify that the HHA meets all of the capitalization requirements addressed in 42 CFR § 489.28. (Note that capitalization need not be reviewed for revalidation, reactivation applications, and changes of ownership that do not require a new/initial enrollment under § 424.550(b).) The

contractor may request from the HHA any and all documentation deemed necessary to perform this task.

The HHA must submit proof of capitalization within 30 calendar days of the contractor's request to do so. Should the HHA fail to furnish said proof and billing privileges have not yet been conveyed, the contractor shall deny the HHA's application pursuant to § 424.530(a)(8)(i) or (ii), as applicable. If billing privileges have been conveyed, the contractor shall revoke the HHA's billing privileges per § 424.535(a)(11).

Should the contractor deem it necessary to verify the HHA's level of capitalization more than once within a given period (e.g., more than once between the time a recommendation is made and the completion of the SOG Location review process), the contractor shall seek approval from its PEOG BFL.

3. Determining Initial Reserve Operating Funds

Initial reserve operating funds are sufficient to meet the requirement of 42 CFR § 489.28(a) if the total amount of such funds is equal to or greater than the product of the actual average cost per visit of three or more similarly situated HHAs in their first year of operation (selected by CMS for comparative purposes) multiplied by the number of visits projected by the HHA for its first 3 months of operation--or 22.5 percent (one fourth of 90 percent) of the average number of visits reported by the comparison HHAs--whichever is greater.

The contractor shall determine the amount of the initial reserve operating funds by using reported cost and visit data from submitted cost reports for the first full year of operation from at least three HHAs that the contractor serves that are comparable to the HHA seeking to enter the Medicare program. Factors to be used in making this determination shall include:

- *Geographic location and urban/rural status;*
- *Number of visits;*
- *Provider-based versus free-standing status; and*
- *Proprietary versus non-proprietary status.*

The adequacy of the required initial reserve operating funds is based on the average cost per visit of the comparable HHAs, by dividing the sum of total reported costs of the HHAs in their first year of operation by the sum of the HHAs' total reported visits. The resulting average cost per visit is then multiplied by the projected visits for the first 3 months of operation of the HHA seeking to enter the program, but not less than 90 percent of average visits for a 3-month period for the HHAs used in determining the average cost per visit.

4. Proof of Operating Funds

As described further in section 10.2.1.6(H)(5) and (7) below, the HHA must provide CMS with adequate proof of the availability of initial reserve operating funds. In some cases, an HHA may have all or part of the initial reserve operating funds in cash equivalents. For purposes of the capitalization requirement, cash equivalents are short-term, highly liquid investments that are readily convertible to known amounts of cash and that present insignificant risk of changes in value. A cash equivalent that is not readily convertible to a known amount of cash as needed during the initial 3-month period for which the initial reserve operating funds are required does not qualify as meeting the initial reserve operating funds requirement. Examples of cash equivalents for purposes of the

capitalization requirement are Treasury bills, commercial paper, and money market funds.

As with funds in a checking, savings, or other account, the HHA also must be able to document the availability of any cash equivalents. CMS may later require the HHA to furnish: (1) another attestation from the financial institution that the funds remain available; and/or (2) documentation from the HHA that any cash equivalents remain available until a date when the HHA will have been surveyed by the state agency or by an approved accrediting organization. The officer of the HHA who will be certifying the accuracy of the information on the HHA's cost report must certify what portion of the required initial reserve operating funds constitutes non-borrowed funds, including funds invested in the business by the owner. That amount must be at least 50 percent of the required initial reserve operating funds. The remainder of the reserve operating funds may be secured through borrowing or line of credit from an unrelated lender.

5. Borrowed Funds

a. General Information

If borrowed funds are not in the same account(s) as the HHA's own non-borrowed funds, the HHA also must provide proof that the borrowed funds are available for use in operating the HHA. As part of this, and except as stated in section 10.2.1.6(H)(5)(b) below, the HHA must (at a minimum) furnish: (1) a copy of the statement(s) of the HHA's savings, checking, or other account(s) containing the borrowed funds; and (2) an attestation from an officer of the bank or other financial institution that the funds are in the account(s) and are immediately available to the HHA. As with the HHA's own (that is, non-borrowed) funds, CMS later may require the HHA to establish the current availability of such borrowed funds; this could include furnishing an attestation from a financial institution or other source (as may be appropriate) to establish that such funds will remain available until a date when the HHA will have been surveyed by the state agency or by an approved accrediting organization.

b. Inability to Obtain Attestation Statements

Several national bank chains are no longer providing attestation statements, which are necessary under 42 CFR § 489.28(d), to verify the existence of capitalization funds for HHAs. Accordingly, the contractor may accept a current bank statement unaccompanied by an attestation from an officer of the bank or other financial institution if the HHA cannot secure the attestation. All efforts must be exhausted, however, to obtain the attestation of funds statement before the contractor can forgo this requirement. In no circumstances shall the MAC instruct the HHA to obtain a different bank that will provide an attestation statement. All other documents listed in section 10.2.1.6(H) must be obtained if required.

6. Line of Credit

If the HHA chooses to support the availability of a portion of the initial reserve operating funds with a line of credit, it must provide CMS with a letter of credit from the lender. CMS later may require the HHA to furnish an attestation from the lender that the HHA, upon its certification into the Medicare program, continues to be approved to borrow the amount specified in the letter of credit.

7. Documents

As part of ensuring the prospective HHA's compliance with the capitalization requirements, the contractor shall obtain the following from the HHA:

- *A document outlining the HHA's projected budget – preferably, a full year's budget broken out by month*
- *A document outlining the number of anticipated visits - preferably a full year broken out by month*
- *An attestation statement from an officer of the HHA defining the source of funds*
- *Copies of bank statements, certificates of deposits, etc., supporting that cash is available (must be current)*
- *Except as stated in section 10.2.1.6(H)(5)(b) above, a letter from an officer of the bank attesting that funds are available*
- *If available, audited financial statements*

The contractor shall also ensure that the capitalization information in Section 12 of the Form CMS-855A is provided.

I. Additional HHA Review Activities

As stated in section 10.2.1.6(H) of this chapter, the contractor must verify that a newly enrolling HHA has the required amount of capitalization after the SOG Location review process is completed but before the contractor conveys Medicare billing privileges to the HHA. Accordingly, the HHA must submit proof of capitalization during this "post-SOG Location" period.

To confirm that the HHA is still in compliance with Medicare enrollment requirements prior to the issuance of a provider agreement and conveyance of Medicare billing privileges, the contractor during the post-SOG Location review period shall ensure that each entity and individual listed in sections 2, 5 and 6 of the HHA's Form CMS-855A application is again reviewed against the Medicare Exclusion Database (MED) and the System for Award Management (SAM) (formerly the General Services Administration (GSA) Access Management System). This activity applies: (1) regardless of whether the HHA is provider-based or freestanding; and (2) only to initial enrollments.

The capitalization and MED/SAM re-reviews described above shall be performed once the SOG Location notifies the contractor via e-mail that the SOG Location's review is complete. (Per sections 10.6.20(A) and 10.6.20(B) of this chapter, a site visit will be performed after the contractor receives the tie-in/approval notice from the SOG Location but before the contractor conveys Medicare billing privileges to the HHA.) If:

***a. The HHA is still in compliance** (e.g., no owners or managing employees are excluded/debarred; capitalization is met):*

i. The contractor shall notify the SOG Location of this via e-mail. The notice shall specify the date on which the contractor completed the aforementioned reviews.

ii. The SOG Location will: (1) CCN; (2) sign a provider agreement; and (3) send a tie-in notice or approval letter to the contractor.

iii. Upon receipt of SOG Location's notification, the contractor will perform the capitalization reviews discussed in section 10.2.1.6(H) and MED/SAM reviews discussed in section 10.2.1.6(I) of this chapter.

***b. The HHA is not in compliance** (e.g., capitalization is not met):*

i. The contractor shall deny the application in accordance with the instructions in this chapter and issue appeal rights. (The denial date shall be the date on which the contractor completed its follow-up capitalization and MED/SAM reviews.)

ii. Notify the SOG Location of the denial via e-mail. (PEOG, not the SOG Location, will handle any corrective action plan (CAP) or appeal related to the contractor's denial.)

iii. Upon receipt of SOG Location's notification, the contractor will perform capitalization reviews discussed in section 10.2.1.6(H) and MED/SAM reviews discussed in section 10.2.1.6(I) of this chapter.

J. Recommendation before New HHA Location Established

If an HHA is adding a branch or changing the location of its main location or an existing branch, the contractor may make a recommendation for approval to the state/SOG Location prior to the establishment of the new/changed location (notwithstanding any other instruction in this chapter to the contrary). If the contractor opts to make such a recommendation prior to the establishment of the new/changed location, it shall note in its recommendation letter that the HHA location has not yet moved or been established.

K. Additional Information

For more information on HHAs, refer to:

- *Sections 1861(o) and 1891 of the Social Security Act*
- *42 CFR Part 484*
- *42 CFR § 489.28 (capitalization)*
- *Pub. 100-07, chapter 2*
- *Pub. 100-04, chapter 10*
- *Pub. 100-02, chapter 7*

10.2.1.7 - Hospices

(Rev. 10868; Issued: 07-14-21; Effective: 08-13-21; Implementation: 08-13-21)

A. General Background Information

A hospice is a public agency or private organization or subdivision of either of these that is primarily engaged in providing a comprehensive set of services such as the assessment and management of pain. Typically, the need for services is identified and coordinated by an interdisciplinary group to provide for the physical, psychosocial, spiritual, and emotional needs of a terminally ill patient and/or family members, as delineated in a specific patient plan of care.

B. Enrollment Information

1. Multiple Practice locations

Hospices are not precluded from having multiple practice locations if permitted by the SOG Location. If the SOG Location disapproves an additional practice location, the

location must seek Medicare approval as a separate hospice with its own enrollment and provider agreement. (See Pub. 100-07, chapter 2, section 2088 for the policies regarding multiple hospice locations.)

2. Site Visits

a. Initial application – If a hospice submits an initial application, the contractor shall order a site visit through PECOS after the contractor receives the tie-in notice (or approval letter) from the SOG Location but before the contractor conveys Medicare billing privileges to the hospice. This is to ensure that the provider is still in compliance with CMS's enrollment requirements. The scope of the site visit will be consistent with section 10.6.20(A) and 10.6.20(B) of this chapter. The NSVC will perform the site visit. The contractor shall not convey Medicare billing privileges to the provider prior to the completion of the NSVC's site visit and the contractor's review of the results.

b. Revalidation – If a hospice submits a revalidation application, the contractor shall order a site visit through PECOS. This is to ensure that the provider is still in compliance with CMS's enrollment requirements. The scope of the site visit will be consistent with sections 10.6.20(A) and 10.6.20(B) of this chapter. The NSVC will perform the site visit. The contractor shall not make a final decision regarding the revalidation application prior to the completion of the NSVC's site visit and the contractor's review of the results.

c. New/changed location - If a hospice is (1) adding a new location or (2) changing the physical location of an existing location, the contractor shall order a site visit of the new/changed location through PECOS after the contractor receives notice of approval from the SOG Location but before the contractor switches the provider's enrollment record to "Approved." This is to ensure that the new/changed location is in compliance with CMS's enrollment requirements. The scope of the site visit will be consistent with sections 10.6.20(A) and 10.6.20(B) of this chapter. The NSVC will perform the site visit. The contractor shall not switch the provider's enrollment record to "Approved" prior to the completion of the NSVC's site visit and the contractor's review of the results.

C. Additional Information:

For more information on hospices, refer to:

- *Sections 1861(u) and 1861(dd) of the Social Security Act*
- *42 CFR Part 418*
- *Pub. 100-07, chapter 2, sections 2080 – 2089*
- *Pub. 100-04, chapter 11*
- *Pub. 100-02, chapter 9*

10.2.1.8 - Hospitals and Hospital Units

(Rev. 10868; Issued: 07-14-21; Effective: 08-13-21; Implementation: 08-13-21)

A. General Background Information

Hospitals and hospital units are a provider type that enrolls via the Form CMS-855A. An exception to this is when the hospital is requesting enrollment to bill for practitioner services for hospital departments, outpatient departments, outpatient locations, and/or hospital clinics; in this circumstance, a new Form CMS-855B enrollment application is required.

B. Enrollment Information

1. Swing-Bed Designation

A "swing-bed" hospital is one that is approved by CMS to furnish post-hospital skilled nursing facility (SNF) services. That is, hospital (or critical access hospital (CAH)) patients' beds can "swing" from furnishing hospital services to providing SNF care without the patient necessarily being moved to another part of the building. It receives a separate survey and certification from that of the hospital. Thus, if swing-bed designation is terminated, the hospital still maintains its certification. In addition, the hospital is given an additional CCN to bill for swing-bed services. (The third digit of the CCN will be the letter U, W, Y or Z.)

In general, and as stated in 42 CFR § 482.58, in order to obtain swing-bed status the hospital must, among other things: (1) have a Medicare provider agreement; (2) be located in a rural area; and (3) have fewer than 100 non-newborn or intensive care beds. Swing-bed hospitals, therefore, are generally small hospitals in rural areas where there may not be enough SNFs, and the hospital is thus used to furnish SNF services.

A separate provider agreement and enrollment for the swing-bed unit is not required. (The hospital's provider agreement incorporates the swing-bed services.) The hospital can add the swing-bed unit as a practice location via the Form CMS-855A.

Additional data on "swing-bed" units can be found in Pub. 100-07, chapter 2, sections 2036 – 2040.

2. Psychiatric and Rehabilitation Units

Though these units receive a state survey, a separate provider agreement and enrollment is not required. (The hospital's provider agreement incorporates these units.) The hospital can add the unit as a practice location to the Form CMS-855A.

3. Multi-Campus Hospitals

A multi-campus hospital (MCH) has two or more hospital campuses operating under one CCN. The MCH would report its various units/campuses as practice locations on the Form CMS-855A. For additional information on multi-campus hospitals, see Pub. 100-07, chapter 2, section 2024.

4. Physician-Owned Hospitals

As defined in 42 CFR § 489.3, a physician-owned hospital (POH) means any participating hospital (as defined in 42 CFR §489.24) in which a physician or an immediate family member of a physician has an ownership or investment interest in the hospital. The ownership or investment interest may be through equity, debt, or other means, and includes an interest in an entity that holds an ownership or investment interest in the hospital. (This definition does not include a hospital with physician ownership or investment interests that satisfy the requirements at 42 CFR § 411.356(a) or (b).)

Section 2(A)(4) of the Form CMS-855A asks the applicant to identify whether it is a physician-owned hospital. If the applicant indicates in Section 2(A)(2) that it is a hospital, it must complete Section 2(A)(4). Applicants that are not hospitals need not complete Section 2(A)(4).

At this time, POHs are not required to submit a completed Form CMS-855POH or a completed Attachment 1 of the Form CMS-855A. As stated in the March 12, 2015 announcement in MLN Connects Provider eNews, CMS has extended the deadline for the POH Initial Annual Ownership/Investment Report due to concerns about the accuracy of the data collected in the report. Future instruction regarding the reporting of POH ownership and investment will be provided on the CMS physician self-referral website.

5. Critical Access Hospitals

Critical access hospitals (CAHs) are not considered to be a hospital sub-type for enrollment purposes. CAHs instead must be enrolled as a separate, distinct provider type. Thus, if an existing hospital wishes to convert to a CAH, it must submit a Form CMS-855A as an initial enrollment.

6. Hospital Addition of Practice Location

In situations where a hospital is adding a practice location, the contractor shall notify the provider in writing that its recommendation for approval does not constitute approval of the facility or group as provider-based under 42 CFR § 413.65.

If the contractor makes a recommendation for approval of the provider's request to add a hospital unit, the contractor shall forward the package to the state agency as described in this chapter.

7. Transplant Programs

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

C. Other Enrollment Procedures

Regarding Section 4 of the Form CMS-855A, the hospital must list all addresses where it - and not a separately enrolled provider or supplier it owns or operates, such as a nursing home - furnishes services. The hospital's primary practice location should be the first location identified in Section 4A and the contractor shall treat it as such – unless there is evidence indicating otherwise. ***NOTE****: Hospital departments located at the same address as the main facility need not be listed as practice locations on the Form CMS-855A.*

If an enrolled hospital seeks to add a rehabilitation, psychiatric, or swing-bed unit, it should submit a Form CMS-855 change of information request and not an initial enrollment application.

D. Non-Participating Emergency Hospitals, Veterans Administration (VA) Hospitals, and Department of Defense (DOD) Hospitals

Non-participating emergency hospitals, VA hospitals and DOD hospitals no longer need to complete a Form CMS-855A enrollment application in order to bill Medicare.

E. Form CMS-855B Applications Submitted by Hospitals

1. Group Practices

If an entity is enrolling via the Form CMS-855B as a hospital-owned clinic/physician practice, the contractor shall contact the applicant to determine whether the latter will be billing any of the listed locations as provider-based. If the applicant will not be billing as provider-based, the contractor shall process the application normally. If, however, the applicant will bill as provider-based, the contractor shall notify the applicant that the hospital must report any changed practice locations to its contractor via the Form CMS-855A.

If the supplier is enrolling as a hospital department (under the "Clinic/Group Practice" category on the Form CMS-855B) or an existing hospital department is undergoing a change of ownership (CHOW), the contractor shall only issue the necessary billing numbers upon notification that a provider agreement has been issued – or, in the case of a CHOW, the provider agreement has been transferred to the new owner. If, however, the supplier is enrolling as a group practice that is merely owned by a hospital (as opposed to being a hospital department), the contractor need not wait until the provider agreement is issued before conveying billing privileges to the group.

2. Individual Billings

Assume an individual physician works for a hospital and will bill for services as an individual (i.e., not as part of the hospital service/payment). However, he/she wants to reassign these benefits to the hospital. The hospital will need to enroll with the contractor via the Form CMS-855B (e.g., as a hospital department, outpatient location).

10.2.1.9 - Indian Health Services (IHS) Facilities

(Rev. 10868; Issued: 07-14-21; Effective: 08-13-21; Implementation: 08-13-21)

A. General Background Information

For purposes of provider enrollment only, there are several types of IHS facilities: (1) those that are wholly owned and operated by the IHS; (2) facilities owned by the IHS but tribally operated; and (3) facilities wholly owned and operated by a tribe, though under the general IHS umbrella. When an IHS facility wishes to enroll with the Part A contractor, it may check in Section 2A of the Form CMS-855A either (a) "Indian Health Services Facility" or (b) the specific provider type it is. For instance, if an IHS hospital is involved, the provider may check "Indian Health Services Facility" or "Hospital" on the application - or perhaps both. Even if it only checked "Hospital," the LBN or DBA Name will typically contain some type of reference to Indian Health Services. The contractor will therefore know that an IHS facility is involved.

The overwhelming majority of IHS facilities on the Part A side are either hospitals, SNFs, CAHs, or ESRD facilities. The contractor processes IHS applications in the same manner (and via the same procedures) as it would with a hospital, SNF, etc. (This also applies to procedures for PECOS entry.)

As for CCNs, the IHS facility uses the same series that its concomitant provider type does. That is, an IHS hospital uses the same CCN series as a "regular" hospital, an IHS CAH utilizes the same series as a regular CAH, and so forth.

B. Enrollment Information

IHS facilities and tribal providers may use Internet-based PECOS or the paper Form CMS-855 enrollment application for their enrollment transactions. The designated Medicare contractor for IHS facilities and tribal providers is Novitas Solutions (Novitas).

If the IHS facility or tribal provider mails its Form CMS-855 to a Medicare contractor other than Novitas, that contractor shall forward the application directly to Novitas at the following address:

Novitas Solutions, Inc.
P.O. Box 3115
Mechanicsburg, PA 17055-1858

C. Licensure Requirements for Physicians and Practitioners Enrolling to Work in or Reassign Benefits to an Indian Tribe or Tribal Organization

The Affordable Care Act (Pub. L 111-148) amended Section 221 of the Indian Health Care Improvement Act such that licensed health professionals employed by a tribal health program are, if licensed in any state, exempt from the licensing requirements of the state in which the tribal program performs the services described in the contract or compact of the tribal health program under the Indian Self-Determination and Education Assistance Act (ISDEAA) (25 U.S.C. 450, et seq.). Pursuant to this statutory provision, therefore, any physician or practitioner need only be licensed in one state – regardless of whether that state is the one in which the practitioner practices – if he or she is employed by a tribal health program performing services as permitted under the ISDEAA (see Pub. 100-04, chapter 19, section 10 for definitions).

The contractor shall apply this policy when processing applications from these individuals. In terms of the effective date of Medicare billing privileges, the contractor shall continue to apply the provisions of 42 CFR §§ 424.520(d) and 424.521(a) and section 10.6.2 of this chapter.

D. Additional Information

For additional general information on IHS facilities, see Pub. 100-04, chapter 19.

10.2.1.10 - Organ Procurement Organizations (OPOs)
(Rev. 10868; Issued: 07-14-21; Effective: 08-13-21; Implementation: 08-13-21)

A. General Background Information

An OPO is an organization that performs or coordinates the procurement, preservation, and transport of organs and maintains a system for locating prospective recipients for available organs. An OPO must have been certified as a qualified OPO by CMS under 42 U.S.C. 273(b) and § 486.303 to be eligible for designation. In order to be certified as a qualified OPO, an OPO must have received a grant under 42 U.S.C. 273(a) or have been certified or re-certified by the Secretary within the previous four years as being a qualified OPO. Under the statute, no new OPOs can enroll into the Medicare program

B. Re-Certification

An OPO is designated for a 4-year agreement cycle. The period may be shorter, for example, if an OPO has voluntarily terminated its agreement with CMS and CMS selects a successor OPO for the balance of the 4-year agreement cycle. Re-certification must occur not more frequently than once every 4 years. The SOG Location is responsible for conducting the re-certification surveys every 4 years; the OPO must sign a new provider

agreement (Form CMS-576A) and participate in the Organ Procurement and Transplantation Network. (See CMS Pub. 100-07, chapter 2, sections 2810 and 2811.)

C. Change in Control/Ownership or Service Area

OPOs can undergo a change in control or ownership or service area (§ 486.310). The merger of one OPO into another or the consolidation of one OPO with another is considered a change in control or ownership. The OPO must notify CMS before implementing a change in ownership or control or a change in its service area. The OPO must provide the SOG Location with information that is specific to the board structure of the new organization, as well as operating budgets, financial information and other documentation that the SOG Location determines to be necessary. The OPO must also submit a revised Form CMS-855 to the MAC for review and a recommendation of approval from the SOG Location. When the SOG Location receives notification of a prospective change in control or ownership for a designated OPO, the SOG Location must determine (based upon the documents and information submitted) that the operation of the OPO will continue uninterrupted during and following the change. For any change of ownership or control, a new CMS Form-576 must be signed.

The instructions in the previous paragraph are in addition to, and not in lieu of, those pertaining to changes of ownership and referrals to SOG Locations in sections 10.6 and 10.6.1 et seq. of this chapter.

D. Additional Information

For more information on OPOs, refer to:

- *Section 1138 of the Social Security Act*
- *42 CFR § 486.301 - § 486.360*
- *Pub. 100-07, chapter 2, sections 2810 – 2821*

For guidance on the appropriate contractor jurisdiction for incoming OPO applications, see CMS Pub. 100-04, chapter 1, section 20. Note that a hospital-based OPO must enroll separately, be separately certified, and sign its own provider agreement.

10.2.1.11 - Outpatient Physical Therapy/Outpatient Speech Pathology Services (OPT/OSP)

(Rev. 10868; Issued: 07-14-21; Effective: 08-13-21; Implementation: 08-13-21)

A. General Background Information

Physical therapists and speech pathologists provide therapy targeting a person's ability to move and perform functional activities in their daily lives typically inhibited by illness or injury. Care is typically coordinated by therapists in conjunction with a physician and is based on an agreed upon plan of care.

B. Enrollment Information

1. Providers of OPT/OSP Services

As explained in Pub. 100-07, chapter 2 section 2292, there are three types of organizations that may qualify as providers of OPT and OSP services under 42 CFR Part 485, Subpart H: clinics, public health clinics, and rehabilitation agencies. However,

rehabilitation agencies are the only organizations that are currently enrolled as a Medicare provider with a CCN. The primary purpose of a rehabilitation agency is to improve or rehabilitate an injury or disability and to tailor a rehabilitation program to meet the specific rehabilitation needs of each patient referred to the agency. A rehabilitation agency must provide, at a minimum, physical therapy and/or speech language pathology services to address those needs of the patients. Social/vocational services are no longer a requirement.

Note that:

- *If an OPT/OSP provider elects to convert to a CORF, it must meet the CORF conditions of coverage and participation. An initial Form CMS-855A enrollment application, state survey, and CMS program approval are also required.*

- *Only those OTP/OSP providers covered under 42 CFR Part 485, Subpart H that furnish OPT/OSP services (as listed above) have provider agreements under 42 CFR § 489.2. Part B physician groups – the supplier type that most people normally associate with the term "clinics" – do not have certified provider or certified supplier agreements.*

- *Occupational therapy cannot be substituted for the physical therapy requirement. It may, however, be provided in addition to physical therapy or speech pathology services. (See Pub. 100-07, chapter 2, section 2292A.)*

2. Extension Locations

As discussed in Pub. 100-07, chapter 2, sections 2298 and 2298A, an OPT/OSP provider can, in certain instances, furnish services from locations other than its primary site. (The provider must designate one location as its primary location on the Form CMS-855A, however.) These sites are called extension locations. An extension location is defined at 42 CFR § 485.703 as "a location or site from which a rehabilitation agency provides services within a portion of the total geographic area served by the primary site. The extension location is part of the agency. The extension location should be located sufficiently close to share administration, supervision, and services in a manner that renders it unnecessary for the extension location to independently meet the conditions of participation as a rehabilitation agency." Per Pub. 100-07, chapter 2, section 2298A, only rehabilitation agencies are permitted to have extension locations. The clinics operated by physicians and public health clinics are not permitted extension locations. These two providers must provide outpatient therapy services at their Medicare approved location.

An OPT/OSP provider may also furnish therapy services in a patient's home or in a patient's room in a SNF. (See Pub. 100-07, chapter 2, section 2300. Note that when the OPT provides services away from the primary site or extension location(s), this is referred to as "off-premises activity" at other locations. Section 2300 (referenced) above discusses such activities.) Because these are not considered extension locations, neither the home nor the patient's room need be listed as a practice location on the provider's Form CMS-855A. (See Pub. 100-07, chapter 2, section 2298B.)

If an OPT/OSP provider wants to add an extension site, a Form CMS-855A change of information request should be submitted.

There is no prohibition against an organization operating on the premises of a supplier (e.g., physician or chiropractor) or another provider as long as they are not operating in the same space at the same time. (See Pub. 100-07, chapter 2, section 2304.)

3. Additional Information

For more information on OPT/OSP providers, refer to:

- *Section 1861(p) of the Social Security Act*
- *42 CFR Part 485, subpart H*
- *Pub. 100-07, chapter 2, sections 2290 – 2308*
- *Pub. 100-07, Appendix E*

10.2.1.12 - Religious Non-Medical Health Care Institutions (RNHCIs)
(Rev. 10868; Issued: 07-14-21; Effective: 08-13-21; Implementation: 08-13-21)

A. General Background Information

RNHCIs furnish only nonmedical nursing services and items to people who choose to rely solely on obtaining a religious method of healing and for whom the acceptance of medical services would be inconsistent with their religious views. Such nonmedical services are performed exclusively through nonmedical nursing personnel who are experienced in caring for the physical needs of nonmedical patients (e.g., caring for the physical needs such as assistance with activities of daily living; assistance in moving, positioning, and ambulation; nutritional needs; and comfort and support measures). RNHCIs do not perform any medical screenings, examinations, diagnoses, or treatments, including the administration of drugs. Each beneficiary who wishes to receive services in an RNHCI must make a valid and formal written statement (or "election") to do so. (The specific election requirements are discussed in 42 CFR § 403.724 and Pub. 100-07, chapter 2, section 2054.1B.)

CMS's Boston Northeast SOG Location (in coordination with the CMS Central Office) has primary responsibility over the approval and certification of RNHCIs. RNHCIs are not certified by the state but must meet all of the conditions of coverage outlined in 42 CFR §403.720 as well as all conditions of participation. (See 42 CFR §§ 403.730 through 403.746 regarding RNCHI conditions of participation.) For purposes of provider enrollment, the three most important conditions are that the provider:

a. Must not be owned by, under common ownership with, or have an ownership interest of 5 percent or more in a provider of medical treatment or services.

b. Must not be affiliated with a provider of medical treatment or services or with an individual who has an ownership interest of 5 percent or more in a provider of medical treatment or services. (Permissible affiliations are described in 42 CFR § 403.738(c)).

c. Must be a non-profit organization per subsection (c)(3) of § 501 of the Internal Revenue Code of 1986, and exempt from taxes under subsection 501(a).

(See Pub. 100-07, chapter 2, section 2054.1 for additional conditions.)

To this end, the contractor shall (1) examine Sections 5 and 6 of the Form CMS-855A and (2) verify the provider's non-profit status to ensure that the aforementioned conditions are met.

B. Additional Information

For more information on RNCHIs, refer to:

- *Section 1861(ss)(1) of the Social Security Act*
- *42 CFR Part 403, subpart G*
- *Pub. 100-07, chapter 2, sections 2054, 2054.1, 2054.1A and 2054.1B*
- *Pub. 100-04, chapter 3, sections 170 - 180*
- *Pub. 100-02, chapter 1, sections 130 – 130.4.2*

For guidance on the appropriate contractor jurisdiction for incoming RNCHI applications, please see Pub. 100-04, chapter 1, section 20.

10.2.1.13 - Rural Health Clinics (RHCs)

(Rev. 10868; Issued: 07-14-21; Effective: 08-13-21; Implementation: 08-13-21)

A. General Background Information

An RHC is a facility located in a rural area designated as a shortage area and is neither a rehabilitation agency nor a facility primarily for the care and treatment of mental diseases. It must meet all other requirements of the RHC regulations at 42 CFR Part 491, subpart A. RHCs:

- *Are considered to be Part B certified suppliers even though they enroll in Medicare via the Form CMS-855A.*
- *Are defined in section 1861(aa)(2) of the Social Security Act as facilities that are engaged primarily in providing services that are typically furnished in an outpatient clinic.*
- *Sign a supplier agreement with CMS (akin to those signed by certified providers). Specifically, RHCs sign the Health Insurance Benefit Agreement (Form CMS-1561A).*
- *Can be either mobile in nature or fixed/permanent locations.*
- *Can be freestanding or provider-based. (As stated in Pub. 100-07, provider-based RHCs are an integral and subordinate part of a hospital (including a critical access hospital (CAH), skilled nursing facility (SNF), or a home health agency (HHA)).*

There are certain services performed by RHCs that do not actually qualify as RHC services. To bill for these services, the clinic must enroll as a Clinic/Group Practice via the Form CMS-855B. It is not uncommon to see RHCs simultaneously enrolled in Medicare via the Form CMS-855A (to bill for RHC services) and the Form CMS-855B (to bill for non-RHC services).

Note that a facility cannot be simultaneously enrolled as an FQHC and an RHC. Though there are similarities between these two supplier types, there are key differences as well. For instance, FQHCs can service rural or urban regions. To be eligible for certification as an RHC, however, a clinic must be located in a non-urbanized area, as determined by

the U.S. Census Bureau, and in an area designated or certified within the previous 4 years by the Secretary of Health and Human Services (HHS), in any one of the four types of shortage area designations that are accepted for RHC certification. (See Pub. 100-02, chapter 13, sections 10.1 and 20.) Also: (1) RHCs are surveyed by the state while FQHCs are not; and (2) FQHCs furnish preventive services while RHCs do not.

B. Additional Information

For more information on RHCs, refer to:

- *Section 1861(aa)(1-2) of the Social Security Act*
- *42 CFR Part 491, subpart A*
- *Pub. 100-07, chapter 2, sections 2240 – 2249*
- *Pub. 100-04, chapter 9*
- *Pub. 100-02, chapter 13*

For guidance on the appropriate contractor jurisdictions for incoming RHC applications, refer to Pub. 100-04, chapter 1, section 20.

10.2.1.14 - Skilled Nursing Facilities (SNFs)

(Rev. 10868; Issued: 07-14-21; Effective: 08-13-21; Implementation: 08-13-21)

A. General Background Information

As stated in Pub. 100-07, chapter 7, section 7004.2, a SNF is a facility that--

- *Is primarily engaged in providing to residents skilled nursing care and related services for residents who require medical or nursing care; or*
- *Is primarily engaged in providing to residents skilled rehabilitation services for the rehabilitation of injured, disabled, or sick persons; while the care and treatment of mental disease is not the primary action of SNFs, the ability to provide appropriate resources and support for these beneficiaries is necessary;*
- *Has in effect a transfer agreement (meeting the requirements of §1861(1) of the Social Security Act with one or more hospitals having agreements in effect under § 1866 of the Social Security Act); and*
- *Meets the requirements for a skilled nursing facility described in subsections (b), (c), and (d) of §1819 of the Social Security Act.*

The transfer agreement mentioned above need not be submitted with the SNF's Form CMS-855A enrollment application; the state and/or SOG Location will verify that the agreement exists.

Like other certified providers, SNFs receive a state survey and sign a provider agreement. SNFs cannot have multiple practice locations under one Form CMS-855A enrollment.

B. SNF Distinct Parts

A SNF can be a separate institution or a "distinct part" of an institution. The term "distinct part" means an area or portion of an institution (e.g., a hospital) that is certified to furnish SNF services. The hospital and the SNF distinct part will each receive a separate CCN. Also:

- *A hospital may have only one SNF distinct part.*

- *"Distinct part" designation is not equivalent to being "provider-based."*

A SNF distinct part unit must enroll separately (i.e., it cannot be listed as a practice location on the hospital's Form CMS-855A), be separately surveyed, and sign a separate provider agreement. (Note how this is different from "swing-bed" units, which do not enroll separately and do not sign separate provider agreements.)

C. Additional Information

For more information on SNFs, refer to:

- *Section 1819 of the Social Security Act*
- *Pub. 100-07, chapter 7*
- *Pub. 100-02, chapter 8*

10.2.1.15 – Miscellaneous Policies
(Rev. 10868; Issued: 07-14-21; Effective: 08-13-21; Implementation: 08-13-21)

Consistent with section 10.4(H)(1) of this chapter, the contractor may return a Form CMS-855A initial application received from a provider or supplier more than 180 days prior to the effective date listed on the application. (Note that this "180 days prior" return reason also applies to Form CMS-855B initial applications received from ambulatory surgical centers and portable x-ray suppliers.)

10.3.3 – Other Enrollment Forms: Information and Processing
(Rev. 10868; Issued: 07-14-21; Effective: 08-13-21; Implementation: 08-13-21)

The forms or form types *described in this section 10.3.3 et seq.* are routinely submitted with an enrollment application.

For purposes of sections 10.3.3.1 and 10.3.3.2, all references to the Form CMS-855 include the Form CMS-20134, unless otherwise stated.

10.3.3.1 – Form CMS-588 – Electronic Funds Transfer (EFT) Authorization Agreement
(Rev. 10868; Issued: 07-14-21; Effective: 08-13-21; Implementation: 08-13-21)

An EFT agreement (Form CMS-588) authorizes CMS to deposit Medicare payments directly into a provider/supplier's bank account.

A. Processing the Form CMS-588 – Specific Situations

When a Form CMS-588 is received, the contractor shall review the form and develop for any deficiencies or missing information prior to approval. The contractor shall enter all EFT data into PECOS.

1. Unsolicited Information

If the provider/supplier submits missing/clarifying data or documentation on its own volition (i.e., without being contacted by the contractor), the contractor shall include this additional data/documentation in its overall form review.

2. Missing or Incorrect Provider Transaction Access Number (PTAN) or CMS Certification Number (CCN) on the Form CMS-588

If the PTAN and/or CCN is missing or incorrect but the contractor can ascertain the correct number (1) via the supporting documents submitted, (2) elsewhere on the form, or (3) via PECOS, the shared systems, or the provider files, the contractor need not pursue development. (Note that social security numbers and employer identification numbers do not fall within this exception.)

3. Missing or Incorrect Social Security Number (SSN) or Employer Identification Number (EIN) Checkbox on the Form CMS-588

If the Form CMS-588 is received and the checkbox for the SSN or EIN is either not checked or is incorrectly checked, the contractor may proceed without further development if the contractor can ascertain the correct option via the supporting documents submitted or elsewhere on the form.

4. Name on Account

As stated on the Form CMS-588, the account to which EFT payments are made must exclusively bear the name of the physician or individual practitioner, or the legal business name (LBN) of the person or entity enrolled with Medicare. Accordingly, the contractor shall accept accounts that (1) solely list the LBN or (2) list the LBN and the Doing Business As name (so long as the LBN is listed first).

B. Form CMS-588 Information Specific to Suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies

For Form CMS-855S enrollments, CMS only requires the Form CMS-588 with initial enrollment applications.

C. Form CMS-588 Signature Requirements

Valid signatures include handwritten (wet) signatures in ink and digital/electronic signatures (e.g., those created by digital signature options or created in software, such as Adobe) shall be accepted. The contractor shall contact its Provider Enrollment & Oversight Group Business Function Lead for questions regarding electronic signatures.

All signatures (handwritten or digital) are valid and appropriate in regards to: (1) signatures on the paper Form CMS-588; and (2) uploaded signatures on the certification statement for Internet-based PECOS forms.

D. Verification

Providers and suppliers may submit a Form CMS-588 via paper or through PECOS. In either case, the contractor shall ensure that:

(i) All EFT arrangements comply with CMS Pub. 100-04, chapter 1, section 30.2.5.

(ii) The information submitted on the Form CMS-588 is complete and accurate. (Except as otherwise stated in this chapter or another CMS directive, the contractor shall develop for any missing information.)

(iii) The provider/supplier submitted (1) a voided check or (2) a letter from the bank verifying the account information.

(iv) The routing number and account number matches what was provided on the Form CMS-588.

*(v) The signature is valid. (**NOTE:** For electronic Form CMS-588 submissions, the provider/supplier can either e-sign the form or upload a signature via PECOS.)*

(vi) The contractor shall forgo development if the "Part I: Reason for Submission (Individual vs. Group)" section is left blank or an incorrect option is selected but the contractor can make the correct determination based on the provider/supplier's existing file or additional information submitted with the application.

Once it has been processed, the Form CMS-588 will be printed and delivered (along with the voided check and bank letter verifying the account information) to the contractor's financial area for proper processing of the EFT data. If this information cannot be verified and the provider/supplier fails to timely respond to a developmental request, the contractor shall reject the Form CMS-588 and, if applicable, the accompanying Form CMS-855 or Form CMS-20134.

During revalidation, the contractor shall develop for the EFT form if the provider/supplier does not have the most current version of Form CMS-588 on file.

E. Miscellaneous EFT Policies

1. Banking Institutions

All payments must be made to a banking institution. EFT payments to non-banking institutions (e.g., brokerage houses, mutual fund families) are not permitted.

If the provider/supplier's bank of choice does not or will not participate in the provider/supplier's proposed EFT arrangement, the provider/supplier must select another financial institution.

2. Sent to the Wrong Unit

If a provider/supplier submits an EFT change request to the contractor but not to the latter's enrollment unit, the recipient unit shall forward it to the enrollment staff, which shall then process the change. The enrollment unit is 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/supplier's Form CMS-855 in the file.

3. Bankruptcies and Garnishments

If the contractor receives a copy of a court order to send payments to a party other than the provider/supplier, it shall contact the applicable SOG Location's Office of General Counsel.

4. Closure of Bank Account

If a provider/supplier has closed its bank/EFT account but will remain enrolled in Medicare, the contractor shall place the provider/supplier on payment withhold until a Form CMS-588 (and Form CMS-855, if applicable) is submitted and approved by the contractor. If such an agreement is not submitted within 90 days after the contractor learned that the account was closed, the contractor shall commence deactivation procedures in accordance with the instructions in this chapter. The basis for deactivation would be § 424.540(a)(2) due to the provider/supplier's failure to submit updated EFT information within 90 days of the change.

5. Reassignments

If a physician or non-physician practitioner is reassigning all of his/her benefits to another supplier and the latter is not currently on EFT, neither the practitioner nor the reassignee needs to submit a Form CMS-588. 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. If, however, the group later submits a change of information request and is not on EFT, it must submit a Form CMS-588.

6. Final Payments

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

7. Chain Organizations

Per CMS Pub. 100-04, chapter 1, section 30.2, a chain organization may have payments to its providers be sent to the chain home office. However, any mass EFT changes (involving large numbers of chain providers) must be submitted and processed in the same fashion as any other change in EFT data. For instance, if a chain has 100 providers and each wants to change its EFT account to that of the chain home office, 100 separate Form CMS-588s must be submitted. If any of the chain providers have never completed a Form CMS-855 before, they must do so at that time.

10.3.3.2 – Form CMS-460 – Medicare Participating Physician or Supplier Agreement

(Rev. 10868; Issued: 07-14-21; Effective: 08-13-21; Implementation: 08-13-21)

This agreement establishes that the Medicare provider/supplier accepts assignment of the Medicare Part B payment for all services (1) for which the participant is eligible to accept assignment under the Medicare law and regulations and (2) which are furnished while the agreement is in effect. (This only applies to suppliers that complete the Forms CMS-855B, CMS-855S, and CMS-855I.) The contractor shall follow the instructions in CMS Pub. 100-04, chapter 1, sections 30 through 30.3.12.3 when handling issues related to par agreements and assignment. Queries concerning the interpretation of such instructions shall be referred to the responsible CMS component.

Individual physicians and non-physician practitioners who only reassign benefits to a clinic/group practice inherit the par status established by the clinic/group practice; accordingly, these physicians and non-physician practitioners need not submit the Form

CMS-460. However, if the individual physician/practitioner maintains a private practice separate from the reassignment, he/she may designate his/her own par status. See the instructions in CMS Pub. 100-04, chapter 1, section 30 for applying the correct par status to clinic/group practices, organizations and individuals in private practice.

A. PECOS Information

All suppliers must choose to be either par or non-par when enrolling and must maintain the same par status across all lines of business. The contractor shall search PECOS to determine if an enrollment already exists with the enrolling provider/supplier's legal business information (i.e.: legal business name, federal tax identification number).

No par status change shall be made by the contractor without confirmation from the provider/supplier first. In the event that a provider/supplier submits a par agreement and they are currently enrolled as non-par, the contractor must confirm with the provider/supplier that the change in the par status is valid for all lines of business. Likewise, if a provider/supplier does not submit a par agreement, and they are enrolled as par or non-par, the contractor shall confirm that the provider/supplier is not changing their current par status across all lines of business.

B. Valid signatures

Valid signatures include handwritten (wet) signatures in ink and digital/electronic signatures (digital or electronic signatures such as those created by digital signature options, created in software, such as Adobe) shall be accepted. The contractor shall contact its CMS Provider Enrollment & Oversight Group Business Function Lead for questions regarding electronic signatures.

All signatures (hand written or digital) are valid and appropriate in regards to: (1) signatures on the paper Form CMS-460; and (2) uploaded signatures on the certification statement for Internet-based PECOS.

10.6.4 – Provider and Supplier Business Structures

(Rev. 10868; Issued: 07-14-21; Effective: 08-13-21; Implementation: 08-13-21)

This section explains the legalities of various types of business organizations that may enroll, including sole proprietorships. Note that the provider's *or supplier's (hereafter occasionally referred to collectively as "provider")* organizational structure can have a significant impact on the type of information it must furnish on the Form CMS-855 or CMS-20134.

Business organizations are generally governed by *s*tate law. Thus, State X may have slightly different rules than State Y regarding certain entities. (In fact, X may permit the creation of certain types of legal entities that Y does not.) The discussion below gives only a broad overview of the principal types of business entities and does not take into account different *s*tate nuances.

Since CMS issues a 1099 based on an enrolled entity's business structure, providers should consult their accountant or legal advisor to ensure that they are establishing the correct business structure.

A. Sole Proprietorships

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

- It files a Schedule C (1040) with the *Internal Revenue Service* (this form reports the business's profits/losses);

- One person owns all of the business's assets; and

- 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). The frequently used term "unincorporated sole proprietorship" is *therefore* a misnomer because sole proprietorships by definition are unincorporated. In addition, merely because the sole proprietor hires employees does not mean the business is no longer a sole proprietorship. Assume that W is a sole proprietor and he hires X, Y, and Z as employees. W's business is still a sole proprietorship because he remains the 100% owner of the business. If, however, W had sold parts of his sole proprietorship to X, Y, and Z, the business would no longer be a sole proprietorship *because* there is now more than one owner.

Note that professional associations (PAs) are generally not considered to be sole proprietorships; the PA designation is typically used in *s*tates that do not allow individuals to incorporate and form professional corporations. The PA will have its own *e*mployer *i*dentification *n*umber and is considered *(*like a professional corporation*)* to be a legal entity that is separate and distinct from the individual.

B. Processing Enrollment*s* for Sole Proprietorships

1. Application Form Sections

If the provider indicates in the Identifying Information/Business Information section of the Form CMS-855A, CMS-855B, CMS-855I, CMS-855S or CMS-20134 that he/she is a sole proprietor, the contractor shall *adhere to* the following:

- The *legal business name (*LBN*)* in the Business Information section should list the person's (the sole proprietor's) legal name.

- The *tax identification number (*TIN*)* in the Business Information section should list the person's social security number.

- The Final Adverse Legal Actions/Convictions section of the Form CMS-855A, CMS-855B, CMS-855I, CMS-855S or CMS-20134 must be completed with information about the individual's final adverse action history.

- The Organizational Ownership and/or Managing Control section of the Form CMS-855A, CMS-855B, CMS-855I, CMS-855S or CMS-20134 will not apply unless the person has hired an entity to exercise *operational or* managerial control over the business (i.e., no owners will be listed in the section, *for* the sole owner has already reported his/her personal information in the Identifying Information and Adverse Legal Actions sections).

- No owners, partners, or directors/officers need to be reported in the Individual Ownership and/or Managing Control section. However, all managing employees (whether W-2 or not) must be listed.

- *If the sole proprietor is not enrolling as a physician or non-physician practitioner via the Form CMS-855I,* he/she may have authorized and delegated officials.

Since most sole proprietorships that complete the Form CMS-855A, CMS-855B, CMS-855I, CMS-855S or CMS-20134 will also have an EIN, the contractor shall request from the provider a copy of its CP-575, any federal tax department tickets, or any other preprinted information from the IRS containing the provider's EIN.

2. Reassignment*s* of *B*enefits

If a physician or non-physician practitioner who is currently reassigning all of his/her benefits attempts to enroll as a sole proprietorship or the sole owner of his/her professional corporation, professional association, or limited liability company, the contractor shall call *or e-mail* the old practice location to determine if the physician or non-physician practitioner is still employed there; if he or she is not, *the contractor shall* contact the practitioner to verify that he or she is indeed attempting to enroll as a sole proprietorship or sole owner.

C. Partnerships

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 the business, each partner owns one-half of Y.

In several respects, 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 with 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; the partners are the partnership. If Y had been a corporation, the owners (A and B) would likely have been 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 he/she earns from the business.

- Unlike a corporation, a partnership generally does not file with the state upon its creation documents *similar to* articles of incorporation. Instead, a partnership has a "partnership agreement," which amounts to 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 *s*tate. Second, a LP has two types of partners –general and limited. The general partner(s) runs the business yet is personally responsible for all of the LP's debts*;* the limited partner(s) has limited liability yet cannot participate in the management of the business.

D. Limited Liability Companies

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 (*as with* stockholders in a corporation). Also, the LLC does not pay *f*ederal taxes (similar to a partnership), although its owners – usually *labeled* "members" - must pay taxes on any dividends they earn.

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

Note that certain Form CMS-855 or *Form* CMS-20134 information is required of different entities. The primary example of this is in the Individual Ownership and/or Managing Control section. 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 th*erefore* need not list them.

E. 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 similar to a partnership and is treated as a partnership for tax purposes. The *core* difference is that *while* a partnership is an ongoing business, a joint venture is a temporary, one-time business undertaking. A joint venture, therefore, *is to some extent* a "temporary partnership."

F. Corporations

A corporation is an entity that is separate and distinct from its owners (called stockholders, or shareholders). To form a corporation, various documents – such as articles of incorporation – must be filed with the *s*tate in which the business will incorporate. The *principal* elements of a corporation are:

- Limited Liability – This is the main reason for a business's decision 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, which now wants to sue X's owners. Unfortunately for Y, it can generally only sue X itself; it cannot sue X's shareholders. The corporation's owners are essentially shielded from liability for *the corporation'* actions because, as stated above, a corporation is separate and distinct from its owners.

  Despite the concept of limited liability, there may be *isolated* instances where a corporation's owners/stockholders can be held personally liable for the corporation's debts. This is known as "piercing the corporate veil."

- "Double" Taxation – This is the principal reason for a business's decision 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, typically called a *b*oard of *d*irectors.

  (As discussed in section 10.6.7.2 of this chapter, there is an important difference between the term "director" in the context of board members and someone who

has "director" in his/her job title (e.g., "Director of Finance"). Simply because an individual works for a corporation as a director of a department, unit, etc., does not automatically mean he/she is a member of the board of directors. If the entity is a corporation, and for purposes for the Individual Ownership and/or Managing Control section of the Form CMS-855 and Form CMS-855, the term "director" means board members.

Two special types of corporations that contractors may encounter are:

- "Professional Corporation" *(*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 a 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, a PC probably cannot be formed (depending, *though*, on what the applicable *s*tate PC statute says). *A PC's* title will usually end in "PC," "PA" (Professional Association)*,* or "Chartered."

- "Close" Corporation *(CC)* (or "closely-held" corporation) – This type of corporation *has* a very limited number of stockholders. Unlike *most* corporations, *a CC*'s board of directors generally does not 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, *s*tate laws governing these entities are often different from those that govern "regular" corporations (i.e., *s*tates 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 its paperwork with the *s*tate.

G. Non-Profit Organizations

The term "non-profit organization" (NPO) *can be* misleading. It does not signify an organization that is *prohibited from* mak*ing* a profit. Rather, it means that all of the organization's profits are put back into the entity to promote its goals, which are usually political, social, religious, or charitable in nature*; a*n NPO is not organized primarily for profit but instead to further some other goal. An entity can acquire NPO status by obtaining a*n IRS* 501(c)(3) certification from the IRS (meaning it is tax-exempt) or by acquiring such status from the *s*tate in which it is located.

NPOs are typically operated and/or managed by a board of trustees or other governing body. NPO status is important for enrollment purposes because NPOs generally do not have owners. *(See section 10.6.4(D)(3) of this chapter for more information on NPO reporting requirements.)*

H. Government-Owned Entities

For purposes of enrollment, a government-owned entity (GOE) exists when a particular government body (e.g., *f*ederal, *s*tate, 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, the Organizational Ownership and/or Managing Control sections of the Form CMS-855 or CMS-20134 need only contain the name of the government body in question. Using our example above, this would be Smith County.

- For the Individual Ownership and/or Managing Control section of the Form CMS-855 or CMS-20134, the only people that must be listed are "managing employees." This is because GOEs do not have corporate officers or directors.

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

10.6.7 – Owning and Managing Information

(Rev. 10868; Issued: 07-14-21; Effective: 08-13-21; Implementation: 08-13-21)

All references to "provider(s)" in sections 10.6.7.1 through 10.6.7.3 include "supplier(s)" (unless noted otherwise).

10.6.7.1 – Organizational Owning and Managing Information

(Rev. 10868; Issued: 07-14-21; Effective: 08-13-21; Implementation: 08-13-21)

Except as stated otherwise, this section 10.6.7.1 only applies to the Organizational Ownership and/or Managing Control Section of the Forms CMS-855A, CMS-855B, CMS-855S and CMS-20134; it is inapplicable to the Form CMS-855I.

A. Ownership Information Required in Forms CMS-855A, CMS-855B, CMS-855S and CMS-20134

All organizations that have any of the following (referenced in (A)(1) through (A)(4) must be listed in the Organizational Ownership and/or Managing Control section of the Form CMS-855 and CMS-20134.

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

(i) Direct Ownership

Examples of direct ownership are as follows:

- *The provider is a skilled nursing facility that is wholly (100%) owned by Company A.*
- *A hospice wants to enroll in Medicare. Company X owns 50% of the hospice.*

In the first example, Company A is considered a direct owner of the skilled nursing facility, in that it actually owns the assets of the business. Likewise, Company X is a direct owner of the hospice mentioned in the second example. It has 50% actual ownership of the hospice.

(ii) Indirect Ownership

Many organizations that directly own a provider are themselves wholly or partly owned by other organizations (or even individuals). This often results from the use of holding companies and parent/subsidiary relationships. Such organizations and individuals are considered "indirect" owners of the provider. The term "indirect ownership interest" (as generally explained in 42 CFR § 420.201) means any ownership interest in an entity that has an ownership in the ownership interest in an entity that has an

interest in the provider or supplier; this also includes an ownership interest in any entity that has an indirect ownership interest in the provider or supplier. Using the first example in the "Direct Ownership" subsection above, if Company B owned 100% of Company A, Company B is considered indirect owner of the provider; in sum, a direct owner has an actual ownership interest in the provider (e.g., owns stock in the business, etc.), whereas an indirect owner has an ownership interest in an organization that owns the provider.

(iii) Examples of Direct vs. Indirect Ownership

The following scenario further illustrates the difference between direct and indirect ownership:

> ***EXAMPLE 1:*** *The supplier listed in the Identifying Information of the Form CMS-855B is an ambulance company that is wholly (100 percent) owned by Company A. 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 terms of the calculation and reporting of indirect ownership interests, consider this example from the Form CMS-855A (though note that individuals would need to be reported in the Individual Ownership and/or Managing Control section of the Form CMS-855A and Form CMS-20134, discussed further below):

EXAMPLE 2

LEVEL 3	***Individual X***	***Individual Y***
	5%	*30%*
LEVEL 2	***Company C***	***Company B***
	60%	*40%*
LEVEL 1	***Company A***	
	100%	

- *Company A owns 100% of the Enrolling Provider*
- *Company B owns 40% of Company A*
- *Company C owns 60% of Company A*
- *Individual X owns 5% of Company C*
- *Individual Y owns 30% of Company B*

In Example 2, Company A (Level 1) is the direct owner of the provider identified in Section 2 of the application. Companies B and C, as well as Individuals X and Y, are indirect owners of the provider. The calculation of ownership shares would be as follows:

LEVEL 1
Company A owns 100% of the Enrolling Provider. Company A must be reported.

LEVEL 2
To calculate the percentage of ownership held by Company C of the Enrolling Provider, multiply the percentage of ownership the LEVEL 1 owner has in the Enrolling Provider by the percentage of ownership the LEVEL 2 owner has in that LEVEL 1 owner.

- *Company A, the LEVEL 1 (or direct) owner, owns 100% of the provider. Company C, a LEVEL 2 owner, owns 60% of Company A. Accordingly, multiply 100% (or 1.0) by 60% (.60). The result is .60. Company C indirectly owns 60% of the Enrolling Provider and must be reported.*
- *Repeat the same procedure for Company B, the other LEVEL 2 owner. Since Company B owns 40% of Company A, multiply this figure by 100% (again, the ownership stake Company A has in the Enrolling Provider). Company B thus owns 40% of the Enrolling Provider and must be reported.*

This process is continued until all LEVEL 2 owners have been accounted for.

LEVEL 3
To calculate the percentage of ownership that Individual X has in the Enrolling Provider, multiply the percentage of ownership the LEVEL 2 owner has in the Enrolling Provider by the percentage of ownership the LEVEL 3 owner has in that LEVEL 2 owner Per Example 2:

- *Company C owns 60% of the provider, and Individual X (Level 3) owns 5% of Company C. Multiplying 60% (.60) by 5% (.05) results in .03. This means that Individual X owns 3% of the provider and need not be reported as an owner.*
- *Repeat this process for Company B, which owns 40% of the provider. Individual Y (Level 3) owns 30% of Company B. Multiplying 40% (.40) by 30% (.30) results in .12, or 12%. Since Individual Y owns 12% of the provider, Individual Y must be reported (in Section 6: Individuals).*

This process is continued until all owners in LEVEL 3 have been accounted for. This process must be repeated for Levels 4 and beyond.

2. 5 percent or greater mortgage or security interest

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.

All entities with at least a 5 percent mortgage, deed of trust, or other security interest in the provider must be reported in the Organizational Ownership and/or Managing Control section. This frequently will include banks, other financial institutions, and investment firms. To calculate whether this interest meets the 5% threshold, divide the dollar amount of the mortgage/deed of trust/other obligation secured by the provider or any of the property or assets of the provider by the dollar amount of the total property and assets of the provider.

***EXAMPLE**: Two years ago, a provider obtained a $20 million loan from Entity X to add a third floor to its facility. Various assets of the provider secure the mortgage. The total value of the provider's property and assets is $100 million.*
Using the above formula, divide $20 million (the dollar amount of the secured mortgage) by $100 million (the total

property and assets of the Enrolling Provider). This results in .20, or 20%. Because Entity X's interest represents at least 5% of the total property and assets of the Enrolling Provider, Entity X must be reported in this section.

3. Partnerships

(a) Any general partnership interest in the provider, regardless of the percentage. *This includes: (1) all interests in a non-limited partnership; and (2) all general partnership interests in a limited partnership.*

(b) For limited partnerships:

- ***Form CMS-855A: Any limited partnership interest that is 10 percent or greater.***

- ***Form CMS-855B and Form CMS-20134: Any limited partnership interest, regardless of the percentage.***

Only partnership interests in the enrolling provider need be disclosed in the Organizational Ownership and/or Managing Control section. Partnership interests in the provider's indirect owners need not be reported. However, if the partnership interest in the indirect owner results in a greater than 5 percent indirect ownership interest in the enrolling provider, this indirect ownership interest would have to be disclosed in this section.

See section 10.6.4(C) of this chapter for more information on the differences between general and limited partnerships.

4. 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 to qualify as a managing organization; for instance, the entity could be a management services organization under contract with the provider to furnish management services for one of the provider's practice locations.

The organizations referred to above generally fall into one or more of the following categories:

- *Corporations*
- *Partnerships and limited partnerships*
- *Limited liability companies*
- *Charitable and religious organizations*
- *Governmental/tribal organizations*
- *Banks and financial institutions*
- *Investment firms*
- *Holding companies*
- *Trusts and trustees*
- *Medical providers/suppliers*
- *Consulting firms*
- *Management services companies*
- *Medical staffing companies*
- *Non-profit entities*

In the Organizational Ownership and/or Managing Control section of the Form CMS-855 and CMS-20134, the provider must indicate the type(s) of organizational categories the reported entity falls into.

B. Special Requirements for Governmental and Tribal Entities

If a federal, state, county, city or other level of government, or an Indian tribe, will be legally and financially responsible for Medicare payments received (including any potential overpayments), the name of that government or Indian tribe should be reported as an owner. The provider must submit a letter on the letterhead of the responsible government (e.g., government agency) or tribal organization attesting that the government or tribal organization will be legally and financially responsible for any outstanding debt owed to CMS. This letter must be signed by an appointed or elected official of the government or tribal organization who has the authority to legally and financially bind the government or tribal organization to the laws, regulations, and program instructions of the Medicare program. This governmental or tribal official, however, need not be an authorized or delegated official, or vice versa; that is, the person need not be one of the provider's authorized or delegated officials listed in the Certification Statement Section of the Form CMS-855 or Form CMS-20134. The only requirement is that the individual have the binding authority described above, and the contractor shall assume such authority exists unless there is evidence to indicate otherwise.

In addition, governmental and tribal entities:

- *Must be identified in the Organizational Ownership and/or Managing Control section even if they are already listed in the Identifying Information section.*

- *Governmental and tribal entities need not submit a copy of an IRS 501(c)(3) form if it is otherwise obvious to the contractor that the entity is a governmental or tribal entity. The contractor can assume that the governmental or tribal entity is non-profit. (See section 10.6.7(D)(3) below and section 10.6.4(G) of this chapter for more information on non-profit entities.)*

C. Submission of Diagram

In addition to completing the Organizational Ownership and/or Managing Control section, the provider must submit an organizational structure diagram/flowchart identifying (1) all of the entities listed in this section; and (2) the relationships they have with the provider and each other. (This applies to the Form CMS-855A, CMS-855B, CMS-855S and CMS-20134.) If the provider is a skilled nursing facility or opioid treatment program, it must also include in the diagram/flowchart all entities and individuals that have less than a 5 percent direct or indirect ownership interest (and were thus not required to otherwise be listed in the Organizational or Individual Ownership and/or Managing Control sections).

The aforementioned diagram/flowchart must be submitted for Form CMS-855 and CMS-20134: (1) initial enrollments; (2) revalidations; (3) reactivations; (4) certified provider and certified supplier changes of ownership based on the principles of 42 § CFR 489.18; and (5) upon any contractor request.

D. Supporting Data/Contractor Request and Additional Information

1. ***IRS CP-575 -*** *Owning/managing organizations need not furnish an IRS CP-575 document unless requested by the contractor (e.g., the contractor discovers a*

potential discrepancy between the organization's reported legal business name and tax identification number).

2. ***Proof of Owning/Managing Control and Percentages -*** *Proof of ownership interest, partnership interest, managerial control, security interest, percentage of ownership or control, etc., need not be submitted unless the contractor requests it. This also means that articles of incorporation, partnership agreements, etc., need not be submitted absent a contractor's request.*

   In addition, the percentage of managing control need not be reported.

3. ***Non-Profit, Charitable and Religious Organizations –*** *As mentioned in section 10.6.4(G) of this chapter, many non-profit organizations are charitable or religious in nature and are generally typically 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 must be reported in the Organizational Ownership and/or Managing Control. (Individual board members should be listed in the Individual Ownership and/or Managing Control section.)*

   Non-profit organizations typically do not have owners, and thus the latter would not need to be listed as such on the application. To confirm its non-profit status, the provider must submit an IRS 501(c)(3) document. If the non-profit entity does have owners, however, they would need to be disclosed in the Ownership and/or Managing Control section consistent with the instructions in section 10.6.7 et seq.

4. ***Duplicate Listing -*** *Any entity listed as the provider in the Identifying Information section of the Form CMS-855A, CMS-855B and CMS-20134 need not be reported in the Organizational Ownership and/or Managing Control section. The only exception involves governmental entities, which must be identified in the Organizational Ownership and/or Managing Control section even if they are already listed in the Identifying Information section.*

5. ***Disregarded Entities -*** *In general, a "disregarded entity" is a term the IRS uses for an LLC that – for federal tax purposes only – is effectively indistinguishable from its single owner/member. The LLC's income and expenses are shown on the owner's personal tax return. The LLC itself does not pay taxes.*

   If an enrolling provider claims that it is a disregarded entity, the contractor need not obtain written confirmation of this from the provider notwithstanding the instruction in the Supporting Documents section of the Form CMS-855 or CMS-20134 that such confirmation is required. As a disregarded entity does not receive a CP-575 form from the IRS confirming its legal business name (LBN) and tax identification number (TIN), the contractor may accept from the enrolling provider any government form (such as a W-9) that lists its LBN and TIN. The disregarded entity's LBN and TIN shall be listed in the Identifying Information/Business Information section of the Form CMS-855.

10.6.7.2 – Individual Owning and Managing Information

(Rev. 10868; Issued: 07-14-21; Effective: 08-13-21; Implementation: 08-13-21)

A. Owning and Managing Individuals Who Must Be Listed in this Section

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

***(i) Ownership** - A 5 percent or greater direct or indirect ownership interest in the provider.*

***(ii) Mortgage/Security Interest** - A 5 percent or greater mortgage or security interest in the provider.*

(iii) Partnership Interests

- *Any general partnership interest in the provider, regardless of the percentage. This includes (1) all interests in a non-limited partnership and (2) all general partnership interests in a limited partnership.*

- *Limited partnerships - For the CMS-855A, any limited partnership interest that is 10 percent or greater. For the Form CMS-855B, CMS-855S and CMS-20134, any limited partnership interest, regardless of the percentage.*

***(iv) 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.*

(v) Corporate Officers and Directors/Board Members

Officers and directors/board members must be listed in the Individual Ownership and/or Managing Control section if – and only 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 this section of the Form CMS-855A, CMS-855B, CMS-855S and CMS-20134.)

Only the enrolling provider's officers and directors must be reported. Board members of the provider's indirect owners need not be disclosed to the extent they are not otherwise required to be reported (e.g., as an owner or managing employee) in this section. However, there may be situations where the officers and directors/board members of the enrolling provider's corporate owner/parent also serve as the enrolling provider's officers and directors/board members. In such cases – and again assuming that the provider is a corporation – the indirect owner's officers and directors/board members would have to be disclosed as the provider's officers and directors/board members in this section.

With respect to corporations, the term "director" refers to members of the board of directors. If a corporation has, for instance, a Director of Finance who nonetheless is not a member of the board of directors, he/she would not need to be listed as a director/board member in this section. However, he/she may need to be listed as a managing employee in this section.

(See sections 10.6.7.1(A) of this chapter for more information on direct and indirect ownership, mortgage and security interests, and partnerships.)

B. Specific Reporting Policies

1. *Proof of Owning/Managing Control and Percentages* – *Proof of ownership interest, partnership interest, managerial control (including W-2s and other proof of employment), security interest, percentage of ownership or control, etc., need not be submitted unless the contractor requests it. This also means that articles of incorporation, partnership agreements, etc., need not be submitted absent a contractor's request.*

2. *Government Entities – Government entities need only report their managing employees, for they do not have owners, partners, corporate officers, or corporate directors.*

3. *Minimum Number of Managing Employees - The provider must report all managing employees but must have at least one if it is completing the Form CMS-855A, CMS-855B, CMS-855S, or CMS-20134. An individual completing the Form CMS-855I need not list a managing employee if he/she does not have one.*

4. *Practice Locations on the Form CMS-855I - All managing employees at all practice locations listed in the Business Information/Practice Location Information section of the Form CMS-855I must be reported in the Managing Employee Information section. The only exceptions to this are individuals who are (a) employed by hospitals, health care facilities, or other organizations shown in the Business Information/Practice Location Information section (e.g., the chief executive officer of a hospital listed in this section) or (ii) managing employees of any group/organization to which the practitioner will be reassigning his/her benefits; these persons need not be reported.*

5. *Partnership Interests Involving Indirect Owners - Only partnership interests in the enrolling provider need be disclosed. Partnership interests in the provider's indirect owners need not be reported. However, if the partnership interest in the indirect owner results in a greater than 5 percent indirect ownership interest in the enrolling provider, this indirect ownership interest would have to be reported.*

10.6.7.3 – Owning and Managing Information – Tax Identification Numbers (TINs)

(Rev. 10868; Issued: 07-14-21; Effective: 08-13-21; Implementation: 08-13-21)

A. General Disclosure Requirement

Consistent with sections 1124 and 1124A of the Social Security Act, the provider must report the TINs (employer identification numbers (EIN) or social security numbers (SSN)) of all entities and individuals listed in the Organizational and Individual Ownership and/or Managing Control sections of the Form CMS-855 and Form CMS-20134. If the provider fails to do so, the contractor shall follow normal development procedures for requesting the TIN.

When documentation of the provider's TIN and/or legal business name (LBN) is required, the contractor may accept a CP-575, a federal tax department ticket, or any other pre-printed document from the IRS that identifies the TIN and/or LBN.

Except as otherwise stated in this chapter, if a provider is changing its TIN the transaction shall be treated as a brand new enrollment as opposed to a change of information; the provider must complete a full Form CMS-855 or CMS-20134 and a new enrollment record must be created in PECOS.

B. TIN Disclosure Requirements for Individuals Who Do Not Have (and Are Ineligible to Obtain) an Employer Identification Number or an SSN from the Social Security Administration (SSA)

In following the normal development procedures for requesting an unreported but required TIN, the contractor shall undertake the applicable steps described in section 10.6.7.3(B)(1) and (2) below if it determines that the TIN was not furnished because the entity or person in question is not eligible to obtain a SSN from the SSA.

1. Contacting Provider

The contractor shall ask the provider (via any means) whether the person or entity can obtain a TIN or, in the case of individuals, an individual taxpayer identification number (ITIN). (Only one inquiry is needed.)

a. If the provider fails to respond to the contractor's inquiry within 30 days, the contractor shall follow the instructions in section 10.6.7.3(B)(2) below.

b. If the provider states that the person or entity is able to obtain a TIN or ITIN, the contractor shall send an e-mail, fax, or letter to the provider stating that: (i) the person or entity must obtain a TIN/ITIN; and (ii) the provider must furnish the TIN/ITIN on the Form CMS-855/20134 with a newly-signed certification statement within 90 days of the contractor's request.

c. If the provider states that the person or entity cannot obtain a TIN or ITIN, the contractor shall send an e-mail, fax, or letter to the provider stating that: (i) the provider must submit written documentation to the contractor explaining why the person or entity cannot legally obtain a TIN or ITIN; and (ii) the explanation – which can be in any written format and may be submitted electronically or via fax – must be submitted within 30 days of the contractor's request.

2. Provider Response

If the provider timely submits the explanation in section 10.6.7.3(B)(1)(c) above, the contractor shall forward the explanation to its CMS Provider Enrollment & Oversight Group Business Function Lead (PEOG BFL); PEOG will notify the contractor as to how the application should be handled. If the provider fails to timely respond to the contractor's inquiry in either section 10.6.7.3(B)(1)(a) or (c), the contractor shall – unless another CMS instruction directs otherwise - reject the application consistent with the procedures identified in this chapter.

3. Clock Stoppages

When the contractor is <u>required</u> under section 10.6.7.3(B)(2) to contact PEOG, the application processing time clock is stopped. It resumes on the date on which the contractor receives PEOG's decision, instruction, or final guidance, as applicable. Interim communication between the contractor and PEOG during such "waiting periods" (e.g., PEOG request for additional information from the contractor) does not restart the clock. Optional communications---that is, communications with PEOG that are not specifically directed under section 10.6.7.3(B)(2)---do not stop the processing clock.

10.6.8 – Billing Agencies

(Rev. 10868; Issued: 07-14-21; Effective: 08-13-21; Implementation: 08-13-21)

A billing agency is an entity *or person* that furnishes billing and collection services on behalf of a provider/supplier. A billing agency *does* not enroll in the Medicare program; *rather, it* submits claims to Medicare in the name and billing number of the provider/*supplier* that furnished the service*(*s*)*. *T*o receive payment directly from Medicare on a *provider/supplier's* behalf, a billing agency must meet the conditions described in § 1842(b)(6)(D) of the Social Security Act.

The provider/*supplier* shall complete the Billing Agency section of the Forms CMS-855A, CMS-855B, CMS-855I, CMS-855S and CMS-20134 with information about all billing agents it utilizes. *(Note that the billing agency address can be listed as a PO Box on the Form CMS-855 and CMS-20134 applications.)* As all Medicare payments must be made via electronic funds transfer, the contractor need not verify the provider's compliance with the "Payment to Agent" rules in CMS Pub. 100-04, chapter 1, section 30.2. The only exception is if the contractor discovers that the "special payments" address in the Practice Location section of the provider's Form CMS-855 or CMS-20134 application belongs to the billing agent or agency. In this situation, the contractor may obtain a copy of the billing agreement if it has reason to believe that the arrangement violates the "Payment to Agent" rules.

For further information on billing agencies, see CMS Pub. 100-04, chapter 1, section 30.2.4.