# CMS Guidance Document	**Department of Health & Human Services (DHHS)**
# Pub 100-08 Medicare Program Integrity	**Centers for Medicare & Medicaid Services (CMS)**
Executive Guidance Number 0288	**Date: February 26, 2008**
Planned Web Site Address http://www.cms.hhs.gov/manuals/	**Release planned: March 11, 2008**

PROGRAM AREA: Provider Authorization

SUBJECT: Clarification of Items in Chapter 10

APPLIES TO: Contractor Specific

I. SUMMARY OF DOCUMENT: This change request clarifies several items in Pub. 100-08, chapter 10 (hereinafter referred to as "chapter 10").

II. CHANGES IN POLICY INSTRUCTIONS: (If not applicable, indicate N/A)
STATUS: R=REVISED, N=NEW, D=DELETED.

Status	CHAPTER/SECTION/SUBSECTION/TITLE
R	10/Table of Contents
R	10/4.4/Practice Location Information
R	10/4.15/Certification Statement
R	10/4.19.6/Desk and Site Reviews
R	10/11.4/Non-Participating Emergency Hospitals and Veterans Administration (VA) Hospitals

III. CLEARANCES:

Clearance & Point of Contact (POC)	Name/Telephone/Component
Senior Official Clearance	Tim Hill/410-786-5448/Director, Office of Financial Management
Agency POC	Frank Whelan/410-786-1302/OFM/PIG/DPSE

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

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

V. STATUTORY OR REGULATORY AUTHORITY: [include the citation of what statute or regulation is being interpreted. If not applicable, indicate N/A]

Attachment - Business Requirements

Pub. 100-08	Transmittal:	Date:	Change Request: 5952

SUBJECT: Clarification of Items in Chapter 10

Effective Date: **30 Days from issuance**
Implementation Date: 30 Days from issuance

I. GENERAL INFORMATION

A. Background: This change request clarifies several items in Pub. 100-08, chapter 10 (hereinafter referred to as "chapter 10").

B. Policy: The purpose of this change request is to update and clarify various topics in chapter 10.

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
5952.1	The contractor shall note that any supplier/individual that submits a CMS-855B or CMS-855I must identify the 9-digit zip code for each practice location listed.	X			X						
5952.2	The contractor shall note that the reference to "remittance advices" has been removed from section 4.4(B) of chapter 10.	X	X	X	X	X					NSC
5952.3	The contractor shall record the results of each independent diagnostic testing facility (IDTF) site visit it performs on the CMS-10221 form.	X			X						
5952.4	The contractor shall note that a non-participating emergency hospital or Veterans Administration (VA) hospital is required to complete and submit a CMS-855A enrollment application and CMS-588 EFT form in order to bill Medicare.	X		X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	None.										

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

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

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs) and Carriers,* use the following statement:

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

Section B: *For Medicare Administrative Contractors (MACs),* use the following statement:

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.

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4.4 – Practice Location Information

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

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

A. Practice Location Verification

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

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

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

In addition:

- If an individual practitioner or group practice: (1) is adding a practice location and (2) is normally required to complete a questionnaire in section 2 of the CMS-855I or CMS-855B specific to its supplier type (e.g., psychologists, physical therapists), the person or entity must submit an updated questionnaire to incorporate services rendered at the new location.

- *Any provider submitting a* CMS-855A*, CMS-855B or CMS-855I application must submit the* 9-digit zip code for each practice location listed.

B. Do Not Forward (DNF)

The contractor shall follow the DNF initiative instructions in Pub. 100-04, chapter 1, section 80.5. *Returned paper checks or EFT payments shall be flagged if returned from the post office or banking institution, respectively, as this may indicate that the provider's "special payment" address (section 4 of the CMS-855) or EFT information has changed. The provider should submit a CMS-855 or CMS-588 request to change this address; if the provider does not have an established enrollment record in PECOS, it must complete an entire CMS-855 application and CMS-588 EFT form.*

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

C. Remittance Notices/Special Payments

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

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

- A CMS-588 that switches its payment mechanism to EFT. (The change request cannot be processed until the CMS-588 is submitted.) All future payments (excluding special payments) must be made via EFT.

- An updated section 4 that identifies the provider's desired "special payments" address.

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

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

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

- One of the provider's practice locations

- A P.O. Box

- The provider's billing agent. The contractor shall request additional information if it has any reason to suspect that the arrangement – at least with respect to any special payments that might be made – may violate the Payment to Agent rules in Pub. 100-04, chapter 1, section 30.2.

- The chain home office address. Per Pub. 100-04, chapter 1, section 30.2, a chain organization may have payments to its providers sent to the chain home office. The legal business name and TIN of the chain home office must be listed on the CMS-588.

- Correspondence address

4.15 – Certification Statement

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CMS-855I

The individual practitioner is the only person who may sign the CMS-855I. (This applies to initial enrollments, changes of information, reactivations, etc.) This includes solely-owned entities listed in section 4A of the CMS-855I. An individual practitioner may not delegate the authority to sign the CMS-855I on his/her behalf to any other person.

CMS-855A and CMS-855B

For initial enrollment and revalidation, the certification statement must be signed and dated by an authorized official of the provider.

The provider can have an unlimited number of authorized officials, so long as each meets the definition of an authorized official. However, each authorized official must be listed in section 6 of the CMS-855.

If an authorized official is listed as a "Contracted Managing Employee" in section 6 of the CMS-855, he/she cannot be an authorized official. The contractor shall notify the provider accordingly. If the person is listed as anything else in section 6 and the contractor has no reason to suspect that the person does not have the authority to sign the application on the provider's behalf, no further investigation is required.

Should the contractor have doubts about an authorized official's authority, it shall contact that official or the applicant's contact person to obtain more information about the official's job title and/or authority to bind. If the contractor remains unconvinced about the official's binding authority, it shall notify the provider that the person cannot be an authorized official. If that person was the only authorized official listed and the provider refuses to list a different authorized official, the contractor shall deny the application.

In addition:

- The signature of an authorized official must be original. Faxed, stamped, or photocopied signatures cannot be accepted.

- If an authorized official is being deleted, the contractor need not obtain: (1) that authorized official's signature, nor (2) documentation verifying that the person no longer is or qualifies as an authorized official.

- A change in authorized officials has no bearing on the authority of existing delegated officials to make changes and/or updates to the provider's status in the Medicare program.

- If the provider is submitting a change of information (e.g., new practice location, change of address, new part-owner) and the authorized official signing the form is not on file, the contractor shall ensure that: (1) the person meets the definition of an authorized official, and (2) section 6 of the CMS-855 is completed for that person. The signature of an existing authorized official is not needed in order to add a new authorized official. Note that the original change request and the addition of the new official shall be treated as a single change request (i.e., one change request encompasses two different actions) for purpose of enrollment processing and reporting.

- The effective date in PECOS for section 15 of the CMS-855 should be the date of signature.

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

- An authorized official must be an authorized official of the provider, not of an owning organization, parent company, or management company. *However, the question of "who is the provider?" is not, for purposes of identifying valid authorized officials, determined solely by the provider's TIN. Rather, the organizational structure is the key factor. For instance, suppose that a chain drug store, Company X, wishes to enroll 100 of its pharmacies with the carrier. Each pharmacy has a separate TIN and, therefore, must enroll separately. Yet all of the pharmacies are part of a single corporate entity – X. In other words, there are not 100 separate corporations in our scenario, but merely one corporation whose individual locations have different TINs. Here, an authorized official for Pharmacy #76, can be someone at X's headquarters (assuming that the definition of authorized official is otherwise met), even though this main office might be operating under a TIN that is different from that of #76. This is because headquarters and Pharmacy #76 are part of the same organization/corporation. Conversely, if #76 was a corporation that was separate and distinct from Company X, only individuals that were part of #76 could be authorized officials.*

4.19.6 – Desk and Site Reviews

(Rev.)

All new IDTF applications shall receive: (1) a thorough desk review, and (2) a mandatory site review prior to the carrier's enrollment of the applicant and issuance of a billing number. The general purpose of both reviews is to determine whether the information listed on Attachment 2 of the CMS-855B is correct, verifiable, and in accordance with all IDTF regulatory and manual requirements.

The contractor shall record the results of each IDTF site visit it performs on the CMS-10221 form.

A. The General Site Review Process

The site visit shall be performed by qualified employees of either the contractor or an individual or organization with which the contractor has contracted for the performance of this function.

B. Mobile Units

Mobile units are required to list their geographic service areas in section 4 of the CMS-855B. Based on the information furnished therein, the carrier shall perform a site visit via the following methods: (1) the mobile unit may visit the office of the site reviewer, or (2) the site reviewer may obtain an advance schedule of the locations the IDTF will be visiting and conduct the site visit at one of those locations.

Units that are performing CPT-4 or HCPCS code procedures that require direct or personal supervision require special attention. To this end, the carrier shall maintain a listing of all mobile IDTFs that perform procedure codes that require such levels of supervision. The carrier shall also discuss with the applicant and all supervisory physicians listed:

- How they will perform these types of supervision on a mobile basis;
- What their responsibilities are;
- That a patient's physician who is performing direct or personal supervision for the IDTF on their patient should be aware of the prohibition concerning physician self-referral for testing (in particular this concerns potentially illegal compensation to the supervisory physician from the IDTF).

C. Changes of Information

Addition of Codes

An enrolled IDTF that wants to perform additional CPT-4 or HCPCS codes must submit a CMS-855B change request. If the additional procedures are of a type and supervision level similar to those previously reported (e.g., an IDTF that performs MRIs for shoulders wants to perform MRIs for hips), a new site visit is typically not required, though the carrier reserves the right to perform one.

If, however, the enrolled IDTF wants to perform additional procedures that are not similar to those previously reported (e.g., an IDTF that conducts sleep studies wants to perform ultrasound tests or skeletal x-rays), the carrier shall perform a site visit. All IDTF claims for the additional procedures shall be suspended until the IDTF: (1) passes all enrollment requirements for the additional procedures (e.g., supervisory physician, non-physician personnel, equipment), and (2) presents evidence that all requirements for the new procedures were met when the tests were actually performed.

If the enrolled IDTF originally listed only general supervision codes and was only reviewed for only general supervision tests, and now wants to perform tests that require direct or personal supervision, the carrier shall promptly suspend all payments for all codes other than those requiring general supervision. A new site visit is required. All IDTF claims for the additional procedures shall be suspended until the IDTF: (1) passes all enrollment requirements for the additional procedures (e.g., supervisory physician, non-physician personnel, equipment), and (2) presents evidence that all requirements for the new procedures were met when the tests were actually performed.

11.4 – *Non-Participating Emergency Hospitals and Veterans Administration (VA) Hospitals*

(Rev.)

A non-participating emergency hospital or VA hospital must complete and submit a CMS-855A enrollment application and CMS-588 EFT form if it wishes to bill Medicare for any services performed.