CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-08 Medicare Program Integrity	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 405	**Date: January 26, 2012**
	Change Request 7698

SUBJECT: General Update to Chapter 15 of the Program Integrity Manual (PIM) - Part III

I. SUMMARY OF CHANGES: The purpose of this change request is to move the remaining sections of Chapter 10 of the Program Integrity Manual (PIM) into Chapter 15 of the PIM.

EFFECTIVE DATE: February 27, 2012

IMPLEMENTATION DATE: February 27, 2012

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
D	10/2.2.8/Cardiac Rehabilitation (CR) and Intensive Cardiac Rehabilitation (ICR)
D	10/3/Pre-Screening and Application Returns
D	10/3.1/Pre-Screening Process
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D	10/4.1/Basic Information (Section 1 of the CMS-855)
D	10/4.2/Identifying Information (Section 2 of the CMS-855)
D	10/4.2.2/Licenses and Certifications
D	10/4.2.3/Correspondence Address
D	10/4.2.4/Accreditation
D	10/4.2.5/Section 2 of the CMS-855A
D	10/4.2.6/Section 2 of the CMS-855B
D	10/4.2.7/Section 2 of the Form CMS-855I
D	10/4.4/Practice Location Information
D	10/4.4.1/Section 4 of the CMS-855A
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D	10/4.12/Special Requirements for Home Health Agencies (HHAs)
D	10/4.13/Contact Person
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D	10/4.15/Certification Statement
D	10/4.16/Delegated Officials
D	10/4.17/Reserved for Future Use
D	10/4.18/Ambulance Attachment

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III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

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

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

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

Attachment - Business Requirements

Pub. 100-08	Transmittal: 405	Date: January 26, 2012	Change Request: 7698

SUBJECT: General Update to Chapter 15 of the Program Integrity Manual (PIM) - Part III

Effective Date: **February 27, 2012**

Implementation Date: February 27, 2012

I. GENERAL INFORMATION

A. Background: This change request (CR) is the third in a series of transmittals designed to update Chapter 15 of the PIM. Specifically, this CR moves the remaining sections of Chapter 10 of the PIM (the "moved sections") into Chapter 15. With the exception of several extremely minor technical edits, the CR does not change any of the verbiage in the moved sections. More substantive updates to the moved sections will be made after this CR has been finalized.

B. Policy: The purposes of this CR are to: (1) continue the ongoing update of Chapter 15 of the PIM, and (2) move the remaining sections of Chapter 10 of the PIM into Chapter 15 of the PIM.

II. BUSINESS REQUIREMENTS 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	
7698.1	The contractor shall note that the remaining sections of Publication 100-08, Chapter 10 are being moved into Publication 100-08, Chapter 15.	X		X	X	X					National Supplier Clearinghouse

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: N/A
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
	None

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

V. CONTACTS

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

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

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers:* No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *For Medicare Administrative Contractors (MACs)*:

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

Medicare Program Integrity Manual
Chapter 15 - Medicare Provider/Supplier Enrollment

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15.3.1 – NPI-Legacy Combinations

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

If the contractor determines that a provider is having claim payment issues due to an incorrect NPI-Provider Transaction Access Number combination or NPI-CMS Certification Number combination entered into the Provider Enrollment, Chain and Ownership System (PECOS) in or after May 2006, the contractor shall request that the provider submit the correct NPI-legacy combination via a Form CMS-855 change of information. The change request can be faxed and the contractor can process the change without receiving the original application and signature by mail. As applicable, the contractor shall verify the faxed signature against the applicant's or authorized official's signature on file, before any changes are made in PECOS.

The contractor shall not use this process to resolve any enrollment issue other than the correction of the NPI-legacy identifier combination. Moreover, the contractor shall not use this process for providers that have not submitted a complete Form CMS-855 enrollment application during or after May 2006. For instance, assume a provider first enrolled in Medicare in December 2005 and has not submitted a complete enrollment application after that date. The provider would be unable to utilize the process described in the previous paragraph.

15.4.1.6 - Home Health Agencies (HHAs)

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

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. All HHA services, moreover, must be part of a plan of care established by a physician, accompanied by a certification from the physician that the patient needs home health services. HHA services can be covered even if the patient lives with someone who might ordinarily be able to perform such services himself/herself.

B. Capitalization and Site Visit Requirements

See section 15.26.2 of this chapter for more information on HHA capitalization requirements. See sections 15.19.2 through 15.19.2.5 for more information on HHA site visit requirements.

C. HHA Components

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

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

Sub-unit – A sub-unit is associated with the parent HHA but services a different geographic area. It is thus considered a semi-autonomous HHA, since it is too far away from the parent HHA to share administration/supervision on a day-to-day basis. This means that HHA sub-units must separately enroll in Medicare, obtain a separate State survey, and sign a separate provider agreement. As with parent HHAs, sub-units receive their own 6-digit CMS Certification Number (CCN).

Branch – A branch is a location or site that services patients in the same geographic area as the parent and shares administration with the parent on a daily basis. Consequently, unlike sub-units, branches need not enroll separately. They can be listed as practice locations on the main provider's (or sub-unit's) Form CMS-855A. Though the branch receives a 10-digit CCN identifier, it bills under the parent HHA's or sub-unit's CCN number.

The question of whether a particular location qualifies as a branch or a sub-unit – which will determine whether a separate Form CMS-855A enrollment is needed – is resolved by the RO.

Consider the following scenario:

PARENT HHA

owns *owns* *owns*

BRANCH A ***SUB-UNIT B*** ***BRANCH C***

operates

BRANCH D

Here, the parent HHA has two branches (A and C) and one sub-unit (B). B also has a branch (D). They will be enrolled as follows:

- *The parent HHA must complete a Form CMS-855A, undergo a State survey, and sign a provider agreement.*

- *Branches A and C must be listed as practice locations on the parent's Form CMS-855A because a branch is sufficiently "attached" to the parent to be considered part of it.*

- *Sub-unit B must: (1) enroll separately from the parent, (2) complete its own Form CMS-855A, (3) undergo its own survey, and (4) sign its own provider agreement. For enrollment purposes, it is considered a separate and distinct entity from the parent, hence requiring a separate enrollment. (This also means that Sub-unit B would not have to be listed on the parent's Form CMS-855A as a practice location.)*

- *Because sub-units, like parents, can have branches, Branch D would be listed as a practice location on Sub-unit B's application.*

See Pub. 100-07, chapter 2, section 2182, for more information on branches.

D. Out-of-State HHA Branches

In general, an HHA can only have a branch in another State (and treat it as a branch, rather than a separate HHA) if there is a reciprocity agreement between the two States. If none exists, the out-of-state location must enroll as a new provider by submitting a new Form CMS-855A and signing a separate provider agreement. It cannot be treated as a branch/practice location of the main HHA. (See Pub. 100-07, chapter 2, section 2184 for specific provisions regarding HHAs that cross State lines.)

E. Additional Data

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, sections 2180 – 2198C (State Operations Manual)*
- *Pub. 100-04, chapter 10 (Claims Processing Manual)*
- *Pub. 100-02, chapter 7 (Benefit Policy Manual)*

15.4.6.3 – Advanced Diagnostic Imaging

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

Section 135(a) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) amended section 1834(e) of the Social Security Act. It required the Secretary to designate organizations to accredit suppliers – including, but not limited to, physicians, non-physician practitioners and independent diagnostic testing facilities - that furnish the technical component (TC) of advanced diagnostic imaging services. MIPPA specifically defines advanced diagnostic imaging procedures as including diagnostic magnetic resonance imaging (MRI), computed tomography (CT), and nuclear medicine imaging such as positron emission tomography (PET). The law also

authorizes the Secretary to specify other diagnostic imaging services in consultation with physician specialty organizations and other stakeholders. In order to furnish the TC of advanced diagnostic imaging services for Medicare beneficiaries, suppliers must be accredited by January 1, 2012. The effective date of the previously named regulation is January 1, 2012.

CMS approved three national accreditation organizations (AOs) – the American College of Radiology, the Intersocietal Accreditation Commission, and the Joint Commission - to provide accreditation services for suppliers of the TC of advanced diagnostic imaging procedures. The accreditation will apply only to the suppliers of the images, not to the physician's interpretation of the image. Also, this accreditation only applies to those who are paid under the Physician Fee Schedule. All accreditation organizations have quality standards that address the safety of the equipment as well as the safety of the patients and staff. A provider submitting claims for the TC must be accredited by January 1, 2012 to be reimbursed for the claim if the service is performed on or after that date. Each of these designated AOs submits monthly reports to CMS that list the suppliers who have been or are accredited, as well as the beginning and end date of the accreditation and the respective modalities for which they receive accreditation.

Newly enrolling physicians and non-physician practitioners described above must complete the Internet-based PECOS or the appropriate CMS-855 and check the appropriate boxes for Advanced Diagnostic Imaging (ADI). Contractors shall accept applications from providers and suppliers who are accredited for the new ADI accreditation. The Medicare enrollment contractors shall verify the information sent on the application meets the current enrollment requirements. The Medicare enrollment contractors shall verify the ADI supplier is listed as one of the accredited individuals/organizations found at www.cms.hhs.gov/Medicareprovidersupenroll and consistent with accreditation information found in section 2 of the CMS-855, and if the application is approved, will enter the information into the Provider Enrollment, Chain and Ownership System (PECOS).

15.5 – *Sections of the Form CMS-855*

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

Sections 15.5.1 through 15.5.16 below discuss the various provisions of the Form CMS-855A, Form CMS-855B, and Form CMS-855I. Not every data element on the forms is discussed here. Only those items that warrant additional instructions or policy clarifications are identified. However, contractors shall abide by all instructions in this chapter 15 in terms of the collection, processing, and verification of all data elements on the Form CMS-855 applications, regardless of whether the data element is discussed in sections 15.5.1 through 15.5.16.

For purposes of these sections, and unless otherwise indicated, the term "approval" includes recommendations for approval.

15.5.1 – *Basic Information (Section 1 of the Form CMS-855)*

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

When processing section 1 of the application, the contractor shall ensure that the provider checks one of the "reason" boxes. It shall also verify, if reported in this section, that the Medicare identification number and NPI are correct.

Note that:

- *If a provider seeks to reestablish itself in the Medicare program after reinstatement from an exclusion, the transaction shall be treated as if it were an initial enrollment.*

- *Hospitals that request enrollment via the Form CMS-855B to bill for practitioner services for hospital departments, outpatient locations and/or hospital clinics must submit an initial enrollment application.*

- *Unless otherwise stated in this chapter, the provider may only check one reason for submittal. Suppose a supplier is changing its TIN. It must enroll as a new supplier as well as request to terminate its existing billing number. The provider must submit two applications: (1) an initial CMS-855B as a new supplier, and (2) a CMS-855B change request/voluntary termination. Both transactions cannot be reported on the same application.*

Further information on the processing of changes of information, changes of ownership (CHOWs), reactivations, deactivations, etc., can be found in the applicable sections of this chapter.

15.5.2 – Identifying Information (Section 2 of the Form CMS-855)

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

Unless specifically indicated otherwise, the instructions in sections 15.5.1 through 15.5.2.3 below apply to the Form CMS-855A, the Form CMS-855B, and the Form CMS-855I.

The instructions in section 15.5.2.4 apply only to the Form CMS-855A; the instructions in section 15.5.2.5 apply only to the Form CMS-855B; and the instructions in section 15.5.2.6 only apply to the Form CMS-855I.

15.5.2.1 – Licenses and Certifications

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

The extent to which the applicant must complete the licensure or certification information in section 2 of the CMS-855 depends upon the provider type involved. For instance, some States may require a particular provider to be "certified" but not "licensed," or vice versa.

A. CMS-855B and CMS-855I

The contractor shall verify that the supplier is licensed and/or certified to furnish services in:

- *The State where the supplier is enrolling;*

- *Any other State within the contractor's jurisdiction in which the supplier (per section 4 of the CMS-855) will maintain a practice location.*

Verification can be performed by reviewing the licensure documentation submitted by the applicant. The only licenses that must be submitted with the application are those required by Medicare or the State to function as the supplier type in question. Licenses and permits that are not of a medical nature are not required, though business licenses needed for the applicant to operate as a health care facility or practice must be submitted. In addition, there may be instances where the supplier is not required to be licensed at all in a particular State; the contractor shall still ensure, however, that the supplier meets all applicable State and Medicare requirements.

The contractor shall also adhere to the following:

- ***State Surveys:*** *Documents that can only be obtained after State surveys or accreditation need not be included as part of the application. (This typically occurs with ambulatory surgical centers (ASCs) and portable x-ray suppliers.) The supplier must, however, furnish those documents that can be submitted prior to the survey/accreditation.*

The contractor need not verify licenses, certifications, and accreditations submitted by ASCs and portable x-ray suppliers. Instead, the contractor shall simply include such documents, if submitted, as part of the enrollment package that is forwarded to the State and/or RO.

Once the contractor receives the approval letter or tie-in notice from the RO for the ASC or portable x-ray supplier, the contractor is encouraged, but not required, to contact the RO, State agency, or supplier for the applicable licensing and/or certification data and to enter it into PECOS.

- ***Notarization:*** *If the applicant submits a license that is not notarized or "certified true," the contractor shall verify the license with the appropriate State agency. (A notarized copy of an original document has a stamp that says "official seal," along with the name of the notary public, the State, the county, and the date the notary's commission expires. A certified "true copy" of an original document has a raised seal that identifies the State and county in which it originated or is stored.)*

- ***Temporary Licenses:*** *If the supplier submits a temporary license, the contractor shall note the expiration date in PECOS. Should the supplier fail to submit the permanent license after the temporary license expiration date, the contractor shall initiate revocation procedures. (A temporary permit – one in which the applicant is not*

yet fully licensed and must complete a specified number of hours of practice in order to obtain the license – is not acceptable.)

- ***Revoked/Suspended Licenses:*** *If the applicant had a previously revoked or suspended license reinstated, the applicant must submit a copy of the reinstatement notice with the application.*

- ***Date of Enrollment –*** *For suppliers other than ASCs and portable x-rays, the date of enrollment is the date the contractor approved the application. The enrollment date cannot be made retroactive. To illustrate, suppose the supplier met all the requirements needed to enroll in Medicare (other than the submission of a CMS-855I) on January 1. He sends his CMS-855I to the contractor on May 1, and the contractor approves the application on June 1. The date of enrollment is June 1, not January 1. (Note that the matter of the date of enrollment is separate from the question of the date from which the supplier may bill.)*

See section 15.7.5.1, of this chapter for special instructions related to periodic license reviews and certain program integrity matters.

B. CMS-855A

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

The contractor need not verify licenses, certifications, and accreditations that were submitted. It shall simply include such documents as part of the enrollment package that is forwarded to the State and/or RO.

Once the contractor receives the approval letter or tie-in notice from the RO, the contractor is encouraged, but not required, to contact the RO, State agency, or provider for the applicable licensing and/certification data and to enter it into PECOS.

15.5.2.2 – Correspondence Address

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

A. General

The correspondence address must be one where the contractor can directly contact the applicant to resolve any issues once the provider is enrolled in the Medicare program. It cannot be the address of a billing agency, management services organization, chain home office, or the provider's representative (e.g., attorney, financial advisor). It can, however, be a P.O. Box or, in the case of an individual practitioner, the person's home address.

The contractor shall call the telephone number listed in this section to verify that the contractor can directly contact the applicant. If an answering service appears and the contractor can identify it as the applicant's personal service, it is not necessary to talk directly to the applicant or an official thereof. The contractor only needs to verify that the applicant can be reached at this number.

B. Contact Person

The contractor should use the contact person listed in section 13 of the CMS-855 for all communications specifically related to the provider's submission of a CMS-855 initial enrollment, change of information request, etc. All other provider enrollment-oriented matters shall be directed to the correspondence address. For instance, assume a provider submits an initial CMS-855 on March 1. The application is approved on April 15. All communications specifically related to the CMS-855 submission between March 1 and April 15 should be sent to the contact person (or, if section 13 is blank, to an authorized/delegated official or the individual practitioner). After April 15, all provider enrollment-oriented correspondence shall go to the correspondence address. Now assume that the provider submits a change of information request on August 1, which the contractor approves on August 30. All communications specifically related to the change request should go to the designated contact person between August 1 and August 30.

Notwithstanding the above, all approval/denial letters should be sent to the contact person. However, the contractor retains the discretion to send the letter to another address listed on the CMS-855 if dictated by circumstances.

In short:

- *The CMS strongly recommends that all communications (e.g., requests for additional information) specifically related to the submission of a CMS-855 (or CMS-588) application be addressed to the contact person in Section 13. However, the contractor retains the discretion to use the correspondence address if circumstances so warrant.*

- *All provider enrollment-oriented communications/correspondence not specifically related to a CMS-855 (or CMS-588) transaction shall be sent to the correspondence address. The contractor has the discretion to determine whether a particular communication is "specifically related" to a CMS-855 submission or whether a particular communication is "provider enrollment-oriented."*

For purposes of this section 15.2.2(B), the term "approved" includes "recommended for approval."

15.5.2.3 – Accreditation

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

If the provider checks "Yes," the contractor shall ensure that the listed accrediting body is one that CMS recognizes in lieu of a State survey or other certification for the provider type in question. If the accrediting body is not recognized by CMS, the contractor shall advise the provider accordingly. (Note, however, that the provider may not intend to use the listed accreditation in lieu of the State survey and merely furnished the accrediting body in response to the question.)

15.5.2.4 – Section 2 of the Form CMS-855A

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

A. Home Health Agency (HHA) Branches, Hospital Units, and Outpatient Physical Therapy/Occupational Therapy (OPT/OT) Extension Sites

As explained in section 15.4.1.6, a branch is a location or site from which an HHA provides services within a portion of the total geographic area served by the parent agency. The branch is part of the HHA and is located sufficiently close to the parent agency such that it shares administration, supervision, and services with the parent. If an existing HHA wishes to add a branch, it is considered a change of information on the CMS-855A. An HHA subunit, meanwhile, is a semi-autonomous organization under the same governing body as the parent HHA and serves patients in a geographic area different from that of the parent. Because of its distance from the subunit, the parent is incapable of sharing administration, supervision and services with the subunit on a daily basis. If the HHA wants to add an HHA subunit, it must complete an initial enrollment application for the subunit. (The subunit also signs a separate provider agreement.)

If an enrolled hospital seeks to add a rehabilitation, psychiatric, or swing-bed unit, it should submit a change of information and not an initial enrollment application. If an OPT/OT provider wishes to add an extension site, a CMS-855 change request should be submitted.

When the provider seeks to add an HHA branch or a hospital unit, the contractor shall make a recommendation for approval or denial and forward the package to the State as described in this chapter. However, the contractor shall emphasize to the provider that a recommendation of approval of the addition of the branch or unit does not signify CMS's approval of the new location. Only the RO can approve the addition.

With respect to PECOS, the contractor shall create a separate enrollment record for the hospital unit. However, a separate enrollment record for each HHA branch and OPT/OT extension site is not required. These locations can simply be listed on the main provider's enrollment record.

B. Critical Access Hospitals

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

C. Transplant Centers

For purposes of Medicare enrollment, a hospital transplant center is treated similarly to a hospital sub-unit. If the hospital wishes to add a transplant center, it must check the "other" box in section 2A2 of the CMS-855A, write "transplant center" 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.

15.5.2.5 – Section 2 of the Form CMS-855B

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

Any supplier that indicates it is an OT/PT group must complete the questionnaire in section 2J. In doing so:

- *If the group indicates that it renders services in patients' homes, the contractor shall verify that the group has an established private practice where it can be contacted directly and where it maintains patients' records.*

- *If the group answers "yes" to question 2, 3, 4, or 5, the contractor shall request a copy of the lease agreement giving the group exclusive use of the facilities for PT/OT services only if it has reason to question the accuracy of the group's response. If the contractor makes this request and the provider cannot furnish a copy of the lease, the contractor shall deny the application.*

15.5.2.6 – Section 2 of the Form CMS-855I

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

A. Specialties

On the CMS-855I, the physician must indicate his/her supplier specialties, showing "P" for primary and "S" for secondary. Non-physician practitioners must indicate their supplier type.

The contractor shall deny the application if the individual fails to meet the requirements of his/her physician specialty or supplier type.

B. Education for Non-Physician Practitioners

The contractor shall verify all required educational information for non-physician practitioners. While the non-physician practitioner must meet all Federal and State requirements, he/she need not provide documentation of courses or degrees taken to satisfy these requirements unless specifically requested to do so by the contractor. To the maximum extent possible, the contractor shall use means other than the

practitioner's submission of documentation- such as a State or school Web site - to validate the person's educational qualifications.

A physician need not submit a copy of his/her degree unless specifically requested to do so by the contractor. To the maximum extent possible, the contractor shall use means other than the physician's submission of documentation- such as a State or school Web site - to validate the person's educational status.

C. Resident/Intern Status

If the applicant is a "resident" in an "approved medical residency program" (as these two terms are defined at 42 CFR §413.75(b)), the contractor shall refer to Pub. 100-02, chapter 15, section 30.3 for further instructions. (The contractor may also want to refer to 42 CFR §415.200, which states that services furnished by residents in approved programs are not "physician services.")

Note that an intern cannot enroll in the Medicare program. (For purposes of this requirement, the term "intern" means an individual who is not licensed by the State because he/she is still in post-graduate year (PGY) 1.) Also, an individual in a residency or fellowship program cannot be reimbursed for services performed as part of that program.

D. Physician Assistants

As stated in the instructions on page 3 of the CMS-855I, physician assistants (PAs) who are enrolling in Medicare need only complete sections 1, 2, 3, 13, 15, and 17 of the CMS- 855I. The physician assistant must furnish his/her NPI in section 1 of the application, and must list his/her employers in section 2E.

The contractor must verify that the employers listed are: (1) enrolled in Medicare, and (2) not excluded or debarred from the Medicare program. (An employer can only receive payment for a PA's services if both are enrolled in Medicare.) All employers must also have an established record in PECOS. If an employer is excluded or debarred, the contractor shall deny the application.

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

E. Psychologists Billing Independently

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

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

All OT/PTs in private practice must respond to the questions in section 2J of the CMS-855I. If the OT/PT plans to provide his/her services as: (1) a member of an established OT/PT group, (2) an employee of a physician-directed group, or (3) an employee of a non-professional corporation, and that person wishes to reassign his/her benefits to that group, this section does not apply. Such information will be captured on the group's CMS-855B application.

If the OT/PT checks that he/she renders all of his/her services in patients' homes, the contractor shall verify that he/she has an established private practice where he/she can be contacted directly and where he/she maintains patient records. (This can be the person's home address, though all Medicare rules and instructions regarding the maintenance of patient records apply.) In addition, section 4D of the CMS-855I should indicate where services are rendered (e.g., county, State, city of the patients' homes). Post office boxes are not acceptable.

If the individual answers "yes" to question 2, 3, 4, or 5, the contractor shall request a copy of the lease agreement giving him/her exclusive use of the facilities for PT/OT services only if it has reason to question the accuracy of his/her response. If the contractor makes this request and the provider cannot furnish a copy of the lease, the contractor shall deny the application.

15.5.3 – Reserved for Future Use

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

15.5.4 – Practice Location Information

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

Unless specifically indicated otherwise, the instructions in this section 15.5.4 apply to the CMS-855A, the CMS-855B, and the CMS-855I.

The instructions in section 15.5.4.1 apply only to the CMS-855A; the instructions in section 15.5.4.2 apply only to the CMS-855B; and the instructions in section 15.5.4.3 only apply to the CMS-855I.

A. Practice Location Verification

The contractor shall verify 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 cannot at first be verified, 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 - via, for instance, the Yellow Pages

or the Internet - 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.

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, remittance notices, 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. The DME MACs are responsible for obtaining, updating and processing CMS-588 changes.

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 also submit:

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

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

The contractor shall 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*

15.5.4.1 – Section 4 of the Form CMS-855A

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

Hospitals and other providers must list all addresses where they (and not a separately enrolled provider/supplier type, such as a nursing home) furnish services. The provider's primary practice location should be the first location identified in section 4 and the contractor shall treat it as such for purposes of PECOS entry, unless there is evidence to the contrary. Note that hospital departments located at the same address as the main facility need not be listed as practice locations on the CMS-855A.

If a practice location (e.g., hospital unit) has a CCN that is in any way different from that of the main provider, the contractor shall create a separate enrollment record in PECOS for that location; this does not apply, however, to HHA branches, OPT/OT extension sites and transplant centers.

The HHAs should complete section 4A with their administrative address.

If the provider's address and/or telephone number cannot be verified, the contractor shall request clarifying information from the provider. If the provider states that the facility and its phone number are not yet operational, the contractor may continue processing the application. However, it shall note in its recommendation letter that the address and telephone number of the facility could not be verified. For purposes of PECOS entry, the contractor can temporarily use the date the certification statement was signed as the effective date.

Verification of HHA Sites

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, it is strongly recommended that the contractor perform a site visit to determine whether the two providers are operating separately. If a site visit cannot be performed and the contractor elects to proceed with a recommendation to the State agency, the contractor shall clearly articulate in its recommendation letter any concerns about potential commingling.

15.5.4.2 – Section 4 of the Form CMS-855B

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

A. Ambulatory Surgical Centers (ASCs) and Portable X-ray Suppliers

If the applicant's address or telephone number cannot be verified, the contractor shall contact the applicant for further information. If the supplier states that the facility or its phone number is not yet operational, the contractor shall continue processing the application. However, it shall note in its recommendation letter that the address and telephone number of the facility could not be verified.

For purposes of PECOS entry, the contractor can temporarily use the date the certification statement was signed as the effective date.

B. Reassignment of Benefits

Per Pub. 100-04, chapter 1, section 30.2.7, a contractor may permit a reassignment of benefits to any eligible entity regardless of where the service was rendered or whether the entity owned or leased that location. As such, the contractor need not verify the entity's ownership or leasing arrangement with respect to the reassignment.

C. Ambulance Companies

If an ambulance company will be furnishing all of its services in the same contractor jurisdiction, the supplier should list:

- *Each site at which its vehicles are garaged in section 4A.*

- *Each site from which its personnel are dispatched in section 4A.*

- *Its base of operations – which, for ambulance companies, is their primary headquarters – in section 4E.*

If the supplier will be furnishing services in more than one jurisdiction, it shall follow the applicable instructions in section 15.5.18 of this chapter.

15.5.4.3 – Section 4 of the Form CMS-855I

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

A. Solely-Owned Organizations

The former practice of having solely-owned practitioner organizations (as explained and defined in section 4A of the CMS-855I) complete a CMS-855B, a CMS-855R, and a CMS-855I has been discontinued. All pertinent data for these organizations can be furnished via the CMS-855I alone. The contractor, however, shall require the supplier to submit a CMS-855B, CMS-855I and CMS-855R if, during the verification process, it discovers that the supplier is not a solely-owned organization. Note that a solely-owned supplier type that normally completes the CMS-855B to enroll in Medicare must still do so. For example, a solely-owned LLC that is an ambulance company must complete the CMS-855B, even though section 4A makes mention of solely-owned LLCs. Use of section 4A of CMS-855I is limited to suppliers that perform physician or practitioner services.

Sole proprietorships need <u>not</u> complete section 4A of the CMS-855I. By definition, a sole proprietorship is not a corporation, professional association, etc. Do not confuse a sole proprietor with a physician whose business is that of a corporation, LLC, etc., of which he/she is the sole owner.

In section 4A, the supplier may list a type of business organization other than a professional corporation, a professional association, or a limited liability company (e.g., closely-held corporation). This is acceptable so long as that business type is recognized by the State in which the supplier is located.

The contractor shall verify all data furnished in section 4A (e.g., legal business name, TIN, adverse legal actions). If section 4A is left blank, the contractor may assume that it does not pertain to the applicant.

A solely-owned physician or practitioner organization that utilizes section 4A to enroll in Medicare can generally submit change of information requests to Medicare via the CMS-855I. However, if the change involves data not captured on the CMS-855I, the change must be made on the applicable CMS form (i.e., CMS-855B, CMS-855R).

B. Individual Affiliations

If the applicant indicates that he/she intends to render all or part of his/her services in a group setting, the contractor shall ensure that the applicant (or the group) has submitted a CMS-855R for each group to which the individual plans to reassign benefits. The contractor shall also verify that the group is enrolled in Medicare. If it is not, the contractor shall enroll the group prior to approving the reassignment.

C. Practice Location Information

A practitioner who only renders services in patients' homes (i.e., house calls) must supply his/her home address in section 4C. In addition, if a practitioner renders services in a retirement or assisted living community, section 4C must include the name and address of that community. In either case, the contractor shall verify that the address is a physical address. Post office boxes and drop boxes are not acceptable.

D. Sole Proprietor Use of EIN

The practitioner must obtain a separate EIN if he/she wants to receive reassigned benefits as a sole proprietor.

E. NPI Information for Groups

If a supplier group/organization is already established in PECOS (i.e., status of "approved), the physician or non-physician practitioner is not required to submit the NPI in 4B2 of the 855I. In short, if group/organization is already established in PECOS, the group/organization does not need to include an NPI in section 4B2. The only NPI that the physician or non-physician practitioner must supply is the NPI found in section 4C.

NOTE: *Physicians and non-physician practitioners are required to supply the NPI in section 4B2 of the CMS-855I for groups/organizations not established in PECOS with a status of "approved."*

15.5.5 – Owning and Managing Organizations

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

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

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

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

The following illustrates the difference between direct and indirect ownership:

EXAMPLE: *The supplier listed in section 2 of the 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 other words, a direct owner has an actual ownership interest in the supplier, whereas an indirect owner has an ownership interest in an organization that owns the supplier.*

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

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

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

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

3. Managing control of the provider.

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

Contractors shall also note the following with respect to owning and managing organizations:

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

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

- *With respect to governmental organizations, the letter referred to in the CMS-855 form instructions for section 5 must be signed by an appointed or elected official of*

the governmental entity who has the authority to legally and financially bind the government to the laws, regulations, and program instructions of Medicare. There is no requirement that this government official also be an authorized official, or vice versa.

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

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

15.5.6 – Owning and Managing Individuals

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

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

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

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

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

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

In addition:

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

- *Government entities need only list their managing employees in section 6 of the CMS-855, as they do not have owners, partners, corporate officers, or corporate directors.*

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

- *All managing employees at any of the practice locations listed in section 4C of the CMS-855I must be reported in section 6A. However, individuals who: (1) are employed by hospitals, health care facilities, or other organizations shown in section 4C (e.g., the CEO of a hospital listed in section 4C), or (2) are managing employees of any group/organization to which the practitioner will be reassigning his/her benefits, need not be reported.*

- *Information on processing section 6B (Adverse Legal Actions) of the CMS-855 can be found in section 4.3 of this chapter.*

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

15.5.7 – Chain Organizations

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

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

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

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

The contractor shall ensure that:

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

- *The chain home office administrator is identified in section 6A of the CMS-855A and that adverse legal action data for the administrator is furnished in section 6B. (For purposes of provider enrollment, a chain home office administrator is automatically deemed to have managing control over the provider.)*

For more information on chain organizations, refer to:

- *Pub. 100-04, chapter 1, sections 20.3 through 20.3.6.*

- *42 CFR §421.404*

- *CMS change request 5720*

15.5.8 – Billing Agencies

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

(Unless otherwise stated, this section applies to the Form CMS-855A, the Form CMS-855B, and the Form CMS-855I.)

The provider shall complete this section with information about all billing agents that prepare and submit claims on its behalf. As all Medicare payments must be made via electronic funds transfer, the contractor no longer needs to verify the provider's compliance with the "Payment to Agent" rules in CMS Publication 100-04, chapter 1, section 30.2. The only exception to this is if the contractor discovers that the "special payments" address in section 4 of the provider's Form CMS-855 application belongs to the billing agent. 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.

If the chain organization listed in section 7 of the Form CMS-855A also serves as the provider's billing agent, the chain must be listed in section 8 as well.

15.5.9 – Reserved for Future Use

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

15.5.10 – Reserved for Future Use

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

15.5.11 – Reserved for Future Use

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

15.5.12 – Special Requirements for Home Health Agencies (HHAs)

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

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

The contractor shall verify that the HHA meets all of the capitalization requirements addressed in 42 CFR §489.28. The contractor may request from the provider any and all documentation deemed necessary to perform this task. Failure to meet the capitalization requirements shall result in a recommendation for denial. For more information on HHA capitalization, review 42 CFR § 489.28 and section 15.26.2 of this chapter.

If the HHA checks "yes" in section 12B, the contractor shall verify the information furnished on the HHA nursing registry (including the tax identification number). (A nursing registry is akin to a staffing agency, whereby a private company furnishes nursing personnel to hospitals, clinics, and other medical providers.)

15.5.13 – Contact Person

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

The contractor should use the contact person listed in section 13 of the Form CMS-855 for all communications specifically related to the provider's submission of a Form CMS-855 initial enrollment, change of information request, etc. All other provider enrollment-oriented matters shall be directed to the correspondence address. To illustrate, assume a provider submits an initial Form CMS-855 on March 1. The application is approved on April 15. All communications specifically related to the Form CMS-855 submission between March 1 and April 15 should have been sent to the contact person (or, if section 13 is blank, to an authorized/delegated official or the individual physician/practitioner). After April 15, all provider enrollment-oriented correspondence shall go to the correspondence address. Now assume that the provider submits a change of information request on August 1, which the contractor approves on August 30. All communications specifically related to the change request should have gone to the designated contact person between August 1 and August 30.

Notwithstanding the above, all approval/denial letters should be sent to the contact person. However, the contractor retains the discretion to send the letter to another address listed on the Form CMS-855 if dictated by circumstances.

In short:

- *CMS strongly recommends that all communications (e.g., requests for additional information) specifically related to the submission of a Form CMS-855 (or Form CMS-588) application be addressed to the contact person in section 13. However, the contractor retains the discretion to use the correspondence address if circumstances so warrant.*

- *All provider enrollment-oriented communications/correspondence not specifically related to a Form CMS-855 (or Form CMS-588) transaction shall be sent to the correspondence address. The contractor has the discretion to*

determine whether a particular communication is "specifically related" to a Form CMS-855 submission or whether a particular communication is "provider enrollment-oriented."

If the contractor discovers that the contact person qualifies as an owning or managing individual, the provider shall list the person in section 6 of the application.

15.5.14 – Reserved for Future Use

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

15.5.15 – Certification Statement

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

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, chain home office, 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 contractor. 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.*

In short, an authorized official must be a 5 percent direct owner, chairman of the board, etc., of the enrolling provider. One cannot use his/her status as the CEO, CFO, etc., of the provider's parent company, management company, or chain home office as a basis for his or her role as an authorized official of the provider.

15.5.16 – Delegated Officials

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

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

A delegated official is an individual who is delegated by an authorized official the authority to report changes and updates to the provider's enrollment record. The delegated official must be an individual with an ownership or control interest in (as that term is defined in section 1124(a)(3) of the Social Security Act), or be a W-2 managing employee of the provider.

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

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

The individual must have been delegated the legal authority by an authorized official listed in section 15 of the CMS-855 to make changes and/or updates to the provider's status in the Medicare program, and to commit the provider to fully abide by the laws, regulations, and program instructions of Medicare.

The contractor shall note the following about delegated officials:

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

employee of the provider. Independent contractors are not considered "managing employees" under section 16 of the CMS-855.

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

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

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

- *The effective date in PECOS for section 16 of the CMS-855 should be the date of signature.*

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

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

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

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

  The delegated official must be a delegated official of <u>the provider</u>, not of an owning organization, parent company, chain home office, or management company. One cannot use his/her status as a W-2 managing employee of the provider's parent company, management company, or chain home office as a basis for his or her role as a delegated official of the provider.

- *If the provider submits a CMS-855 change of information, the contractor may accept the signature of a delegated official in Section 15 or 16 of the CMS-855.*

15.5.17 – Reserved for Future Use

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

15.5.18 – Ambulance Attachment

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

A. Geographic Area

The applicant must list the geographic areas in which it provides services. If the supplier indicates that it provides services in more than one contractor's jurisdiction, it must submit a separate CMS-855B to each contractor.

B. Licensure Information

With respect to licensure:

- *The contractor shall ensure that the supplier submits all applicable licenses and certificates.*

- *If the supplier performs services in multiples States within the same contractor jurisdiction, it must submit all necessary licenses and certificates for each State. Separate full CMS-855Bs are not required for each State; however, the contractor shall create separate enrollment records in PECOS for each.*

- *An air ambulance supplier that is enrolling in a State to which it flies in order to pick up patients (that is, a State other than where its base of operations is located) is not required to have a practice location or place of business in that State. So long as the air ambulance supplier meets all other criteria for enrollment in Medicare, the contractor for that State may not deny the supplier's enrollment application solely on the grounds that the supplier does not have a practice location in that State. (This policy only applies to air ambulance suppliers.)*

C. Paramedic Intercept Information

Paramedic intercept services typically involves an arrangement between a basic life support (BLS) ambulance supplier and an advanced life support (ALS) ambulance supplier, whereby the latter provides the ALS services and the BLS supplier provides the transportation component. (See 42 CFR §410.40 for more information.) If the applicant indicates that it has such an arrangement, it must attach a copy of the agreement/contract.

D. Vehicle Information

Air ambulance suppliers must submit the following:

- *A written statement signed by the president, chief executive officer, or chief operating officer that gives the name and address of the facility where the aircraft is hangared; and*

- *Proof that the air ambulance supplier or its leasing company possesses a valid charter flight license (FAA Part 135 Certificate) for the aircraft being used as an air ambulance. If the air medical transportation company owns the aircraft, the owner's name on the FAA Part 135 certificate must be the same as the supplier's name on the enrollment application. If the air medical transportation company leases the aircraft from another entity, a copy of the lease agreement must accompany the enrollment application. The name of the company leasing the aircraft from that other entity must be the same as the supplier's name on the enrollment application.*

E. Hospital-Based Ambulances

An ambulance service that is owned and operated by a hospital need not complete a CMS-855B if:

- *The ambulance services will appear on the hospital's cost-report; and*

- *The hospital possesses all licenses required by the State or locality to operate the ambulance service.*

If the hospital decides to divest itself of the ambulance service, the latter will have to complete a CMS-855B if it wishes to bill Medicare.

15.5.19 – IDTF Attachment

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

Sections 15.5.19 through 15.5.19.7 of this chapter contain provider enrollment instructions regarding entities that must enroll as and bill for the technical component of diagnostic tests as an independent diagnostic testing facility (IDTF).

15.5.19.1 – IDTF Standards

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

A. IDTF Standards

Consistent with 42 CFR §410.33(g), each IDTF must certify on its CMS-855B enrollment application that it meets the following standards and all other requirements:

1. *Operates its business in compliance with all applicable Federal and State licensure and regulatory requirements for the health and safety of patients.*

    - *The purpose of this standard is to ensure that suppliers are licensed in the business and specialties being provided to Medicare beneficiaries. Licenses are required by State and/or Federal agencies to make certain that guidelines and*

regulations are being followed to ensure businesses are furnishing quality services to Medicare beneficiaries.

- *The responsibility for determining what licenses are required to operate a supplier's business is the sole responsibility of the supplier. The contractor is not responsible for notifying any supplier of what licenses are required or that any changes have occurred in the licensure requirements. No exemptions to applicable State licensing requirements are permitted, except when granted by the State.*

- *The contractor shall not grant billing privileges to any business not appropriately licensed as required by the appropriate State or Federal agency. If a supplier is found providing services for which it is not properly licensed, billing privileges may be revoked and appropriate recoupment actions taken.*

2. Provides complete and accurate information on its enrollment application. Changes in ownership, changes of location, changes in general supervision, and adverse legal actions must be reported to the Medicare fee-for-service contractor on the Medicare enrollment application within 30 calendar days of the change. All other changes to the enrollment application must be reported within 90 days.

NOTE: This 30-day requirement takes precedence over the certification in section 15 of the CMS-855B whereby the supplier agrees to notify Medicare of any changes to its enrollment data within 90 days of the effective date of the change. By signing the certification statement, the IDTF agrees to abide by all Medicare rules for its supplier type, including the 30-day rule in 42 CFR §410.33(g)(2).

3. Maintain a physical facility on an appropriate site. For the purposes of this standard, a post office box, commercial mailbox, hotel, or motel is not considered an appropriate site. The physical facility, including mobile units, must contain space for equipment appropriate to the services designated on the enrollment application, facilities for hand washing, adequate patient privacy accommodations, and the storage of both business records and current medical records within the office setting of the IDTF, or IDTF home office, not within the actual mobile unit.

- *IDTF suppliers that provide services remotely and do not see beneficiaries at their practice location are exempt from providing hand washing and adequate patient privacy accommodations.*

- *The requirements in 42 CFR §410.33(g)(3) take precedence over the guidelines in sections 15.5.4 and 15.5.4.2 of this chapter pertaining to the supplier's practice location requirements.*

- *The physical location must have an address, including the suite identifier, which is recognized by the United States Postal Service (USPS).*

4. Has all applicable diagnostic testing equipment available at the physical site excluding portable diagnostic testing equipment. The IDTF must—

(i) Maintain a catalog of portable diagnostic equipment, including diagnostic testing equipment serial numbers at the physical site;

(ii) Make portable diagnostic testing equipment available for inspection within 2 business days of a CMS inspection request; and

(iii) Maintain a current inventory of the diagnostic testing equipment, including serial and registration numbers, and provide this information to the designated fee-for-service contractor upon request, and notify the contractor of any changes in equipment within 90 days.

5. Maintain a primary business phone under the name of the designated business. The IDTF must have its--

(i) Primary business phone located at the designated site of the business or within the home office of the mobile IDTF units.

(ii) Telephone or toll free telephone numbers available in a local directory and through directory assistance.

The requirements in 42 CFR §410.33(g)(5) take precedence over the guidelines in sections 15.5.4 and 15.5.4.2 of this chapter pertaining to the supplier's telephone requirements.

IDTFs may not use "call forwarding" or an answering service as their primary method of receiving calls from beneficiaries during posted operating hours.

6. Have a comprehensive liability insurance policy of at least $300,000 per location that covers both the place of business and all customers and employees of the IDTF. The policy must be carried by a nonrelative-owned company. Failure to maintain required insurance at all times will result in revocation of the IDTF's billing privileges retroactive to the date the insurance lapsed. IDTF suppliers are responsible for providing the contact information for the issuing insurance agent and the underwriter. In addition, the IDTF must--

(i) Ensure that the insurance policy must remain in force at all times and provide coverage of at least $300,000 per incident; and

(ii) Notify the CMS designated contractor in writing of any policy changes or cancellations.

7. Agree not to directly solicit patients, which includes - but is not limited to - a prohibition on telephone, computer, or in-person contacts. The IDTF must accept only those patients referred for diagnostic testing by an attending physician, who is furnishing a consultation or treating a beneficiary for a specific medical problem and

who uses the results in the management of the beneficiary's specific medical problem. Nonphysician practitioners may order tests as set forth in §410.32(a)(3).

- *By the signature of the authorized official in section 15 of the CMS-855B, the IDTF agrees to comply with 42 CFR §410.33(g)(7).*

- *The supplier is prohibited from directly contacting any individual beneficiary for the purposes of soliciting business for the IDTF. This includes contacting the individual beneficiary by telephone or via door-to-door sales.*

- *There is no prohibition on television, radio or Internet advertisements, mass mailings, or similar efforts to attract potential clients to an IDTF.*

- *If the contractor determines that an IDTF is violating this standard, the contractor should notify its Provider Enrollment Operations Group (PEOG) liaison immediately.*

8. Answer, document, and maintain documentation of a beneficiary's written clinical complaint at the physical site of the IDTF (For mobile IDTFs, this documentation would be stored at their home office.) This includes, but is not limited to, the following:

(i) The name, address, telephone number, and health insurance claim number of the beneficiary.

(ii) The date the complaint was received; the name of the person receiving the complaint; and a summary of actions taken to resolve the complaint.

(iii) If an investigation was not conducted, the name of the person making the decision and the reason for the decision.

9. Openly post these standards for review by patients and the public.

10. Disclose to the government any person having ownership, financial, or control interest or any other legal interest in the supplier at the time of enrollment or within 30 days of a change.

11. Have its testing equipment calibrated and maintained per equipment instructions and in compliance with applicable manufacturers suggested maintenance and calibration standards.

12. Have technical staff on duty with the appropriate credentials to perform tests. The IDTF must be able to produce the applicable Federal or State licenses or certifications of the individuals performing these services.

13. Have proper medical record storage and be able to retrieve medical records upon request from CMS or its fee-for-service contractor within 2 business days.

14. Permit CMS, including its agents, or its designated fee-for-service contractors, to conduct unannounced, on-site inspections to confirm the IDTF's compliance with these standards. The IDTF must---

(i) Be accessible during regular business hours to CMS and beneficiaries; and

(ii) Maintain a visible sign posting its normal business hours.

15. Enrolls in Medicare for any diagnostic testing services that it furnishes to a Medicare beneficiary, regardless of whether the service is furnished in a mobile or fixed base location.

16. Bills for all mobile diagnostic services that are furnished to a Medicare beneficiary, unless the mobile diagnostic service is part of a service provided under arrangement as described in section 1861(w)(1) of the Act. (Section 1861(w)(1) states that the term "arrangements" is limited to arrangements under which receipt of payments by the hospital, critical access hospital, skilled nursing facility, home health agency or hospice program (whether in its own right or as agent), with respect to services for which an individual is entitled to have payment made under this title, discharges the liability of such individual or any other person to pay for the services.)

If the IDTF claims that it is furnishing services under arrangement as described in section 1861(w)(1), the IDTF must provide documentation of such with its initial or revalidation CMS-855 application.

The IDTF must meet all of the standards in 42 CFR §410.33 – as well as all other Federal and State statutory and regulatory requirements – in order to be enrolled in, and to maintain its enrollment in, the Medicare program. Failure to meet any of the standards in 42 CFR §410.33 or any other applicable requirements will result in the denial of the supplier's CMS-855 application or, if the supplier is already enrolled in Medicare, the revocation of its Medicare billing privileges.

B. Sharing of Space and Equipment

Effective January 1, 2008, with the exception of hospital-based and mobile IDTFs, a fixed-base IDTF does not: (i) share a practice location with another Medicare-enrolled individual or organization; (ii) lease or sublease its operations or its practice location to another Medicare-enrolled individual or organization; or (iii) share diagnostic testing equipment used in the initial diagnostic test with another Medicare-enrolled individual or organization. (See 42 CFR §410.33(g)(15).)

Effective January 1, 2008, if the contractor determines that an IDTF is leasing or subleasing its operations to another organization or individual, the contractor shall revoke the supplier's Medicare billing privileges.

Note that while the prohibition against the sharing of space at a practice location is effective on January 1, 2008, for newly-enrolling IDTFs (including those with applications that are still pending as of January 1, 2008), the space-sharing provision

in 42 CFR §410.33(g)(15)(i) for IDTFs that are currently occupying a practice location with another Medicare-enrolled individual or organization will not become effective until January 1, 2009.

C. One Enrollment per Practice Location

The IDTFs must separately enroll each of their practice locations (with the exception of locations that are used solely as warehouses or repair facilities). This means that each enrolling IDTF can only have one practice location on its CMS-855B enrollment application; thus, if an IDTF is adding a practice location to its existing enrollment, it must submit a new, complete CMS-855B application for that location and have that location undergo a separate site visit. Also, each of the IDTF's mobile units must enroll separately. Consequently, if a fixed IDTF site also contains a mobile unit, the mobile unit must enroll separately from the fixed location.

For those IDTFs with multiple practice locations that were enrolled prior to the implementation date of this instruction, each practice location of the IDTF must meet all of applicable IDTF requirements, including those listed in this chapter. Failure to comply with any of these requirements at any practice location represent the supplier's noncompliance with 42 CFR §410.33 as a whole, and will result in the revocation of its Medicare billing privileges.

D. Effective Date of Billing Privileges

Effective January 1, 2008, the filing date of the Medicare enrollment application is the date that the Medicare contractor receives a signed provider enrollment application that it is able to process to approval. (See 42 CFR 410.33(i).) The effective date of billing privileges for a newly enrolled IDTF is the later of the following:

(1) The filing date of the Medicare enrollment application that was subsequently approved by a Medicare fee-for-service contractor; or

(2) The date the IDTF first started furnishing services at its new practice location.

A newly-enrolled IDTF, therefore, may not receive reimbursement for services furnished before the effective date of billing privileges.

The contractor shall note that if it rejects an IDTF application on or after January 1, 2008, and a new application is later submitted, the date of filing is the date the contractor receives the new enrollment application.

E. Leasing and Staffing

For purposes of the provisions in 42 CFR §410.33, a "mobile IDTF" does not include entities that lease or contract with a Medicare enrolled provider or supplier to provide: a) diagnostic testing equipment; b) non-physician personnel described in 42 CFR 410.33(c); or c) diagnostic testing equipment and non-physician personnel described in

42 CFR 410.33(c). This is because the provider/supplier is responsible for providing the appropriate level of physician supervision for the diagnostic testing.

15.5.19.2 – Multi-State IDTF Entities

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

As stated in 42 CFR § 410.33(e)(1), an IDTF that operates across State boundaries must:

- *Maintain documentation that its supervising physicians and technicians are licensed and certified in each of the States in which it operates; and*

- *Operate in compliance with all applicable Federal, State, and local licensure and regulatory requirements with regard to the health and safety of patients.*

The point of the actual delivery of service means the place of service on the claim form. When the IDTF performs or administers an entire diagnostic test at the beneficiary's location, the beneficiary's location is the place of service. When one or more aspects of the diagnostic testing are performed at the IDTF, the IDTF is the place of service.

15.5.19.3 – Interpreting Physicians

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

The applicant shall list all physicians for whose diagnostic test interpretations it will bill. This includes physicians who will provide interpretations subject to the anti-markup payment limitation as detailed in Pub. 100-04, chapter 1, §30.2.9; whether the service is provided to the IDTF on a contract basis or is reassigned.

The contractor shall ensure and document that:

- *All listed physicians are enrolled in Medicare.*

- *All interpreting physicians who are reassigning their benefits to the IDTF have the right to do so.*

- *All required CMS-855R forms have been submitted.*

- *The interpreting physicians listed are qualified to interpret the types of tests (codes) listed. (The contractor may need to contact another contractor to obtain this information.) If the applicant does not list any interpreting physicians, the contractor need not request additional information because the applicant may not be billing for the interpretations; that is, the physicians may be billing for the interpretation themselves.*

If an interpreting physician has been recently added or changed, the new interpreting physician must have met all of the interpreting physician requirements at the time any tests were performed.

15.5.19.4 – Technicians

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

Each non-physician who performs the IDTF diagnostic tests must be listed. These persons are often referred to as technicians.

A. Licensure and Certification

All technicians must meet the standards of a State license or State certification at the time of the IDTF's enrollment. Contractors may not grant temporary exemptions from such requirements. Also, the IDTF must attach a copy of each technician's license or certification with its application.

B. Changes of Technicians

If a technician has been recently added or changed, the updated information must be reported via a CMS-855B change request. The new technician must have met all of the necessary credentialing requirements at the time any tests were performed.

If the contractor receives notification from a technician that he/she is no longer performing tests at the IDTF, the contractor shall request from the supplier a CMS-855B change of information. If the provider did not have another technician qualified to perform the tests listed on the current application, the supplier must submit significant documentation in the form of payroll records, etc. to substantiate the performance of the test by a properly qualified technician after the date the original technician was no longer performing procedures at the IDTF.

15.5.19.5 – Supervising Physicians

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

A. General Principles

Under 42 CFR §410.33(b)(1), an IDTF must have one or more supervising physicians who are responsible for:

- *The direct and ongoing oversight of the quality of the testing performed;*
- *The proper operation and calibration of equipment used to perform tests; and*
- *The qualifications of non-physician IDTF personnel who use the equipment.*

Of course, not every supervising physician has to be responsible for all of these functions. For instance, one supervising physician can be responsible for the operation

and calibration of equipment, while other supervising physicians can be responsible for test supervision and the qualifications of non-physician personnel. The basic requirement, however, is that all the supervisory physician functions must be properly met at each location, regardless of the number of physicians involved. This is particularly applicable to mobile IDTF units that are allowed to use different supervisory physicians at different locations. They may have a different physician supervise the test at each location. The physicians used need only meet the proficiency standards for the tests they are supervising.

Under 42 CFR §410.33(b)(1), each supervising physician must be limited to providing supervision to no more than three IDTF sites. This applies to both fixed sites and mobile units where three concurrent operations are capable of performing tests.

B. Information about the Supervising Physicians

The contractor shall check and document that each supervisory physician: (1) is licensed to practice in the State(s) where the diagnostic tests he or she supervises will be performed, (2) is Medicare enrolled, and (3) is not currently excluded or debarred. The physician(s) need not necessarily be Medicare enrolled in the State where the IDTF is enrolled.

In addition:

- *The contractor shall verify the licensure for the State where the IDTF is being enrolled for each supervisory physician enrolled with another contractor, based upon the physician's license submission and discussions with the contractor where they are enrolled.*

- *Each physician of the group who actually performs an IDTF supervisory function must be listed.*

- *If a supervising physician has been recently added or changed, the updated information must be reported via a CMS-855B change request. The new physician must have met all the supervising physician requirements at the time any tests were performed.*

- *If the contractor knows that a listed supervisory physician has been listed with several other IDTFs, the contractor shall check with the physician to determine whether the physician is still acting as supervisory physician for the previously enrolled IDTFs.*

C. General, Direct, and Personal Supervision

Under 42 CFR §410.33(b)(2), if a procedure requires the direct or personal supervision of a physician as set forth in 42 CFR §410.32(b)(3), the contractor shall ensure that the IDTF's supervisory physician furnishes this level of supervision.

The contractor's enrollment staff shall be familiar with the definitions of personal, direct and general supervision set forth at 42 CFR §410.32(b)(3), and shall ensure that the applicant has checked the highest required level of supervision for the tests being performed.

Each box that begins with "Assumes responsibility," must be checked. However, as indicated previously, the boxes can be checked through the use of more than one physician.

D. Attestation Statement for Supervising Physicians

A separate attestation statement must be completed and signed by each supervisory physician listed. If Question E2 is not completed, the contractor may assume that the supervisory physician in question supervises for all codes listed in section 2 of the IDTF attachment – unless the contractor has reason to suspect otherwise. If Question E2 is completed, the contractor shall ensure that all codes listed in section 2 are covered through the use of multiple supervisory physicians.

With respect to physician verification, the contractor shall:

- *Check the signature on the attestation against that of the enrolled physician;*

- *Contact each supervisory physician by telephone (or as part of the required site visit) to verify that the physician: (1) actually exists (e.g., is not using a phony or inactive physician number); (2) indeed signed the attestation; and (3) is aware of his or her responsibilities.*

If the physician is enrolled with a different contractor, the contractor shall contact the latter contractor and obtain the listed telephone number of the physician.

15.5.19.6 – Desk and Site Reviews

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

All new IDTF applications shall receive: (1) a thorough desk review, and (2) a mandatory site review prior to the contractor'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 chapter 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 contractor 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 contractor shall maintain a listing of all mobile IDTFs that perform procedure codes that require such levels of supervision. The contractor 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 contractor reserves the right to perform one.

If, however, the enrolled IDTF wants to perform additional procedures that are <u>not</u> similar to those previously reported (e.g., an IDTF that conducts sleep studies wants to perform ultrasound tests or skeletal x-rays), the contractor 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 contractor 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.

15.5.19.7 – Special Procedures and Supplier Types
(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

A. Diagnostic Mammography

If an IDTF performs diagnostic mammography services, it must have a Food and Drug Administration (FDA) certification to perform the mammography. However, an entity that only performs diagnostic mammography services should not be enrolled as an IDTF. Rather, it should be separately enrolled as a mammography center.

B. CLIA Tests

An IDTF may not perform or bill for CLIA tests. However, an entity with one tax identification number (TIN) may own both an IDTF and an independent CLIA laboratory. In such a situation, they should be separately enrolled and advised to bill separately. The contractor shall also advise its claims unit to ensure that the CLIA codes are not being billed under the IDTF provider number.

15.5.20 – Processing Form CMS-855R Applications
(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

A. General Information

A CMS-855R application must be completed for any individual who will: (1) reassign his/her benefits to an eligible entity, or (2) terminate an existing reassignment.

If the individual who wants to reassign his or her benefits is not enrolled in Medicare, the person must complete a CMS-855I as well as the CMS-855R. (The CMS-855I and CMS-855R can be submitted concurrently.) Moreover, if the entity to which the person's benefits will be reassigned is not enrolled in Medicare, the organization must complete a CMS-855B. (See section 15.7.6 for additional instructions regarding the joint processing of CMS-855Rs, CMS-855Bs, and CMS-855Is.)

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

In addition:

- *An individual can receive reassigned benefits. The most common example of this is a physician or practitioner who reassigns his/her benefits to a physician who is either: (1) a sole proprietor, or (2) the sole owner of an entity listed in section 4A of the CMS-855I. Here, the only forms that will be required are the CMS-855R, and separate*

CMS-855Is from the reassignor and the reassignee. (No CMS-855B is implicated.) The reassignee himself/herself must sign section 4B of the CMS-855R, as there is no authorized or delegated official involved.

- *The contractor shall follow the instructions in Pub. 100-04, chapter 1, section 30.2 to ensure that a group or person is eligible to receive reassigned benefits.*

- *If the individual is initiating a reassignment, both he/she and the group's authorized or delegated official must sign section 4 of the CMS-855R. If either of the two signatures is missing, the contractor may return the application per section 15.8.1 of this chapter.*

- *If the person (or group) is terminating a reassignment, either party may sign section 4 of the CMS-855R; obtaining both signatures is not required. If no signatures are present, the contractor may return the application per section 15.8.1 of this chapter.*

- *A CMS-855R is required to terminate a reassignment. The termination cannot be done via the CMS-855I.*

- *The authorized or delegated official who signs section 4 of the CMS-855R must be someone who is currently on file with the contractor as such. If this is a new enrollment, with a joint submission of the CMS-855B, CMS-855I, and CMS-855R, the person must be listed on the CMS-855B as an authorized or delegated official.*

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

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

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

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

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

B. ASCs and Reassignment

Physicians and non-physician practitioners who meet the reassignment exceptions in 42 CFR §424.80, and Pub. 100-04, chapter 1, sections 30.2.6 and 30.2.7, may reassign their benefits to an ASC.

If a physician or non-physician practitioner wishes to reassign its benefits to an existing (that is, a currently-enrolled) ASC, both the individual and the entity must sign the CMS-855R. However, it is not necessary for the ASC to separately enroll as a group practice in order to receive benefits. It can accept reassignment as an ASC.

C. Reassignment and Revoked/Deceased Physicians and Non-Physician Practitioners

There are situations where a physician/non-physician practitioner (the "owning physician/practitioner") owns 100% of his/her own practice, employs another physician (the "employed physician/practitioner") to work with him/her, and accepts reassigned benefits from the employed physician/practitioner. Should the sole proprietor or sole owner die or have his/her billing privileges revoked, the practice is automatically dissolved for purposes of Medicare enrollment and all reassignments to the practice are automatically terminated as well. Neither the owning physician/practitioner nor the practice is enrolled in Medicare any longer and the billing privileges for both shall be revoked in accordance with the revocation procedures outlined in this chapter. (It is immaterial whether the practice was established as a sole proprietorship, a PC, a PA, or a solely-owned LLC.) In addition, the contractor shall end-date the reassignment using, as applicable, the date of death or the effective date of the revocation.

Besides revoking the billing privileges of the owning physician/practitioner and the practice, the contractor shall notify the employed physician/practitioner that:

(1) The practice's billing privileges have been revoked;

(2) Any services furnished by him/her on behalf of the practice after the date of the owning physician/practitioner's death will not be paid; and

(3) If the employed physician/practitioner wishes to provide services at the former practice's location, he/she must submit via Internet-based PECOS (or a paper CMS-855 application) a CMS-855I change of information request to add the owning physician/practitioner's practice location as a new location of the employed physician/practitioner. For purposes of this section 15.5.20(C)(3) only, submission of a (1) complete CMS-855I application as an initial enrollment and (2) a terminating CMS-855R application are not required – even if the employed physician/non-physician practitioner had reassigned all of his/her benefits to the practice.

15.7.1.1 – Pre-Screening Process

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

A. Paper Applications

Within 20 calendar days after the application is received in the contractor's mailroom, the contractor shall complete a "pre-screen" of the application. The purpose of the pre-screening process is to ensure that the provider, at the time the application was originally submitted:

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

- *Furnished all required supporting documentation needed to process the requested enrollment action.*

If the provider: (1) files an application with at least one missing required data element, or (2) fails to submit all required supporting documentation, the contractor shall send a letter to the provider – preferably via e-mail or fax - that contains, at a minimum, the elements listed below. (The letter must be sent within the aforementioned 20-day period.)

- *A list of all missing data or documentation;*

- *A request that the provider submit the data within 30 calendar days;*

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

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

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

Note that the pre-screening letter is the only request for missing information or missing documentation that the contractor must make. Also, and as a reminder, a prescreening letter is not required if the provider submitted a complete application and all applicable supporting documentation.

In addition:

- ***Missing Information Available Elsewhere** – Even if the provider's application contains missing information that is nevertheless detected elsewhere on the form, in the supporting documentation, or on another enrollment form, the contractor must still*

send a pre-screening letter requesting the provider to furnish the missing data on the CMS-855.

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

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

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

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

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

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

NOTE: *"Pending" as an acceptable response does not apply to DMEPOS supplier applicants.*

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

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

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

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

- ***Relationship to the Verification Process –*** *It is important that the contractor review section 15.7.2.2 of this chapter for information on requesting additional (or "clarifying") information and how this is tied to the pre-screening process.*

B. Internet-Based PECOS Applications

The prescreening process, as described in section 15.7.1.1, must be completed within 15 calendar days for Internet-based applications.

15.7.2.1 – Reserved for Future Use

15.7.2.2 – Requesting and Receiving Clarifying Information

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

A. Requesting Clarifying Data

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

1. *A list of all data to be clarified and documentation to be submitted;*

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

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

4. *The CMS Web site at which the CMS-855 forms can be found. The contractor shall instruct the provider to: (1) print out the page(s) containing the data in question; (2) enter the data on the blank page; (3) sign and date a new, blank certification statement; and (4) send it to the contractor. (As an alternative, the contractor can fax the blank page(s) and certification statement to the provider.) The provider need not furnish its initials next to the data element(s) in question.*

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

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

In addition:

- ***Only One Request Needed*** *- The "clarification letter" is the only request for clarification that the contractor must make. Obviously, the contractor should respond to any of the provider's telephone calls, e-mails, etc., resulting from the clarification letter. However, the contractor need not – on its own volition –*

make an additional request for clarification unless it uncovers missing information that it failed to previously spot.

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

- ***Policy Application –*** *Unless stated otherwise in this chapter, the policies enunciated in this section 15.7.2.2 apply to all CMS-855 applications identified in this chapter (e.g., changes of information, reassignments).*

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

  Moreover, if the provider furnishes some, but not all, of the requested data within the applicable time period, the contractor is not required to contact the provider again to request the rest of the information. For instance, suppose the contractor requested clarification of certain items in Sections 3, 4 and 5 of the CMS-855A. Clarification was only furnished with respect to the Section 3 information. The contractor has the discretion to wait until the expiration of the 30-day period and then reject the application; however, as stated above, it should take into account any good-faith efforts of the provider to furnish the information.

- ***Rejections vs. Denials*** *– For providers and suppliers covered by section 15.8.4 of this chapter that are submitting an initial application or a change request to add a practice location: If the provider failed to fully comply with the contractor's request for additional or clarifying information, there are two possible outcomes:*

  - *Rejection of the application under 42 CFR §424.525(a), due to the provider's failure to furnish the missing data or documentation, or*

  - *Denial of the application if one of the denial reasons in section 15.8.4 of this chapter is implicated.*

  If the contractor is faced with this situation, it is free to contact its Provider Enrollment Operations Group (PEOG) liaison for guidance prior to making its decision to reject or deny.

- ***Commencement of Timeframe*** *– For information requests under 42 CFR §424.525(a)(1), the 30-day clock described above commences when the contractor mails, faxes, or e-mails the letter.*

B. Relationship to the Pre-Screening Process

The contractor may begin the verification process during the pre-screening phase. If the contractor, in doing so, uncovers data requiring further development (e.g., problems verifying the SSN of a managing employee; indications that a person may be using two SSNs), the contractor may include this request for clarifying information within the pre-screening letter. This, in turn, means that the provider must furnish: (1) all missing data and documentation requested in the pre-screening letter within the applicable timeframe specified in 42 CFR §424.525(a), and (2) all clarifications asked for in the contractor's request for clarifying information within the applicable timeframe specified in 42 CFR § 424.525(a).

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

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

Now suppose that the contractor had not completed the entire verification process by March 16. In its pre-screening letter, the contractor identified the missing information and requested clarification of the two SSN discrepancies. The contractor completed the validation process on April 2; that same day, the contractor sent a request for additional information to the provider regarding two EIN discrepancies. In this scenario, the provider must furnish the missing information and SSN clarifications by April 13. Even if it does so, it must still provide the EIN clarifications by May 1 (or 30 days after the April 2 letter was sent). If the provider fails to comply with the March 14 letter, the contractor may reject the application on April 13 without waiting to see if the provider can furnish the requested EIN clarifications.

C. Receiving Clarifying Information

Unless stated otherwise in this chapter, any data collected on the CMS-855 for which the contractor requested clarification must be furnished by the provider on the applicable page(s) of the CMS-855. A newly-signed and dated certification statement must also be submitted. Note that this certification statement must be separate and

distinct from the previous certification statement; that is, the provider cannot simply add its signature to the existing statement. It must sign a separate one.

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

D. Unsolicited Submission of Clarifying Information

Any new or changed information submitted by an applicant prior to the date the contractor finishes processing the application is considered to be an update to the original application. (It is immaterial whether the data was requested by the contractor.) The data is not considered to be a separate change of information. For instance, suppose the provider submitted an initial enrollment application to the contractor. On the 58th day – one day before the contractor planned to make its recommendation for approval – the provider on its own volition submitted updates to its section 6 data. The contractor must process this information prior to making its recommendation, even if it takes the application beyond the 30-day limit. The contractor cannot make its recommendation as planned on the 59th day and simply process the section 6 data as a change of information after the fact. Of course, if the late-arriving data takes the timeframe over 60 days, the contractor should document the file and explain the special circumstances involved.

E. Site Visits

In addition to the site visits required for all IDTF, DME and CMHC applicants (which have their own site visit instructions), the contractor may conduct site visits: (1) of other applicants seeking enrollment in the Medicare program, or (2) to verify the status of currently enrolled providers. Such site visits should be unannounced; the contractor representatives shall always conduct themselves in a professional manner, disclosing to the provider appropriate identifying credentials and explaining the purpose of the visit. The contractor shall maintain records of all site visits to support decisions regarding the denial or revocation of a Medicare billing number.

15.7.5 - Special Program Integrity Procedures

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

This section contains additional verification procedures that the contractor shall utilize when processing the following transactions:

- *Changes in the provider's practice location*
- *Changes in provider's correspondence or special payment address*
- *On the CMS-588, changes in the provider's bank name, depository routing transit number, or depository account number*

- *Reactivations*

The purpose of these instructions is to ensure that the Medicare billing privileges of physicians, non-physician practitioners, and organizational providers/suppliers are protected and that Medicare only pays qualified individuals and organizations. Note that the instructions in this section 15.7.5 are in addition to, and not in lieu of, all other verification instructions contained in this chapter. Also, unless otherwise stated, section 15.7.5 applies to the CMS-855A, the CMS-855B and the CMS-855I.

A. Change in Practice Location Address

In cases where a provider submits a CMS-855 request to change its practice location address, the contractor shall undertake the following activities:

1. Compare the signature thereon with the same person's signature on file to ensure that the signatures match. If they do not, the contractor shall request additional information from the signatory to confirm his or her identity. Proper identification includes a photocopy of a current passport or a photocopy of a driver's license. If the individual fails to submit this information or if the contractor determines that the supporting documentation does not verify the person's identity, the contractor shall deny the application.

For the CMS-855A and CMS-855B, if the person's signature is not already on file, the contractor shall request that he/she complete section 6 of the CMS-855 and furnish his/her signature in section 15 or 16 of the CMS-855.

2. Contact the location currently associated with the provider in PECOS or MCS to verify that the provider is no longer there and did in fact move.

3. Request that the provider fax to the contractor a copy of his/her driver's license or, if applicable, a copy of a phone bill/power bill containing the business's new LBN or DBA name and its new address.

B. Change in Correspondence or Special Payments Address

If the provider submits a change to its correspondence or special payments address, the contractor shall undertake the following activities:

1. Compare the signature thereon with the same person's signature on file to ensure that the signatures match. If they do not, the contractor shall request additional information from the signatory to confirm his or her identity. Proper identification includes a photocopy of a current passport or a photocopy of a driver's license. If the individual fails to submit this information or if the contractor determines that the supporting documentation does not verify the person's identity, the contractor shall deny the application.

For the CMS-855A and CMS-855B, if the person's signature is not already on file, the contractor shall request that he/she complete section 6 of the CMS-855 and furnish his/her signature in section 15 or 16 of the CMS-855.

2. Contact the provider (or, for a CMS-855A or CMS-855B application, an authorized or delegated official) to verify the change.

C. Change of EFT Information

If the provider submits a CMS-588 request to change the bank name, depository routing transit number, or depository account number, the contractor shall undertake the following activities:

1. Compare the signature thereon with the same person's signature on file to ensure that the signatures match. If they do not, the contractor shall request additional information from the signatory to confirm his or her identity. Proper identification includes a photocopy of a current passport or a photocopy of a driver's license. If the individual fails to submit this information or if the contractor determines that the supporting documentation does not verify the person's identity, the contractor shall deny the application.

For organizational providers, if the person's signature is not already on file, the contractor shall request that he/she complete section 6 of the CMS-855 and furnish his/her signature in section 15 or 16 of the CMS-855.

2. Contact the provider (or, for a CMS-855A or CMS-855B application, an authorized or delegated official thereof) to verify the change.

D. Reactivations and Revalidations

When processing a CMS-855 reactivation or revalidation application, the contractor shall undertake the following activities:

1. Compare the signature thereon with the same person's signature on file to ensure that the signatures match. If they do not, the contractor shall request additional information from the signatory to confirm his or her identity. Proper identification includes a photocopy of a current passport or a photocopy of a driver's license. If the individual fails to submit this information or if the contractor determines that the supporting documentation does not verify the person's identity, the contractor shall deny the application.

For the CMS-855A and CMS-855B, if the person's signature is not already on file, the contractor shall request that he/she complete section 6 of the CMS-855 and furnish his/her signature in section 15 or 16 of the CMS-855.

2. If the: (a) practice location address or (b) correspondence/special payment address on the application is different than that which is currently associated with the provider

in PECOS or MCS, the contractor shall abide by the instructions in subsections A and B above, respectively.

3. (Reactivations only): Request that the provider furnish a copy of a claim that it plans to submit upon the reactivation of its billing privileges. Alternatively, the provider may submit on letterhead the following information regarding a beneficiary to whom the provider has furnished services and for whom it will submit a claim: (1) beneficiary name, (2) health insurance claim number (HICN), (3) date of service, and (4) phone number.

E. Reassignment of All Benefits

If a physician or non-physician practitioner who is currently reassigning all of his or her benefits attempts to enroll as a sole proprietorship or the sole owner of his or her professional corporation, association or LLC, the contractor shall:

1. Compare the signature thereon with the same person's signature on file to ensure that the signatures match. If they do not, the contractor shall request additional information from the signatory to confirm his or her identity. Proper identification includes a photocopy of a current passport or a photocopy of a driver's license. If the individual fails to submit this information or if the contractor determines that the supporting documentation does not verify the person's identity, the contractor shall deny the application.

2. Call the old practice location to determine if the physician or non-physician practitioner is still employed there; if he or she is not, contact the practitioner to verify that he or she is indeed attempting to enroll as a sole proprietorship or sole owner and request that he/she fax to the contractor a copy of his/her driver's license.

F. Referral to PSCs or ZPICs

In conducting the verification activities described in this section 16, if the contractor believes that a case of identify theft or other fraudulent activity likely exists (e.g., physician or practitioner indicates that he or she is <u>not</u> establishing a new practice location or changing his or her EFT information, and that the application submitted in his/her name is false), the contractor shall deny the application and refer the matter to the PSC or ZPIC.

15.7.5.1 - Special Procedures for Physicians and Non-Physician Practitioners

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

To help ensure that only qualified physicians and non-physician practitioners are enrolled in Medicare, the contractor shall undertake the activities described below.

For purposes of this section, the term "practitioner" includes both physicians and non-physician practitioners. In addition, the instructions in this section, apply only to these practitioners.

A. Monthly Reviews

No later than the 15th day of each month, the contractor shall review State licensing board information for each State within its jurisdiction to determine whether any of its currently enrolled practitioners have, within the previous 60 days:

1. Had their medical license revoked, suspended or inactivated (due to retirement, death, or voluntary surrender of license);

2. Otherwise lost their medical license or have had their licenses expire.

For those practitioners who no longer have a valid medical license, the contractor shall take the necessary steps to revoke the individual's billing privileges.

The mechanism by which the contractor shall perform these monthly licensure reviews lies within its discretion, though the most cost-effective method shall be used.

B. Relocation to a New State

1. Licensure Reviews

When a practitioner submits a CMS-855I application to either: (1) add a practice location in a new State, or (2) relocate to a new State entirely, the contractor that received the application shall review State licensing board information for the "prior" State to determine:

1. Whether the practitioner had his or her medical license revoked, suspended, or inactivated (due to retirement, death, or voluntary surrender of license), or otherwise lost his or her license, and

2. If the practitioner has indeed lost his or her medical license, whether he or she reported this information to Medicare via the CMS-855I within the timeframe specified in 42 CFR 424.520.

If the practitioner is currently enrolled and did not report the adverse action to Medicare in a timely manner, the contractor shall revoke the practitioner's Medicare billing privileges and establish a 1-year enrollment bar. If the practitioner is submitting an initial enrollment application (e.g., is moving to a new State and contractor jurisdiction) and did not report the adverse action in section 3 of the CMS-855I, the contractor shall deny the enrollment application and establish a 3-year enrollment bar.

2. Voluntary Withdrawal Reminder

When a practitioner submits a CMS-855I application to either: (1) add a practice location in a new State, or (2) relocate to a new State entirely, the contractor that received the application shall determine whether the practitioner still has an active

PECOS enrollment record in the "other" State(s). If PECOS indeed indicates that the individual has an active practice location in the other State(s), the contractor shall remind the practitioner that if he/she no longer intends to practice in that State, he/she must submit a CMS-855 voluntary termination application to the contractor for that jurisdiction. The reminder should be given in the approval letter that the receiving contractor sends to the practitioner or, if more appropriate, in an e-mail or other form of written correspondence.

C. Break in Medical Practice

If the contractor receives a CMS-855I from a practitioner who was once enrolled in Medicare but who has not been enrolled with any Medicare contractor for the previous 2 years, the contractor shall verify with the State where the practitioner last worked whether the practitioner was convicted of a felony or had his or her license suspended or revoked. If such an adverse action was imposed, the contractor shall take action in accordance with the instructions in this chapter.

D. Distant EFT Account

Whether as part of an initial enrollment or a change request, if the practitioner wants to establish an EFT account: (1) in a State other than where the practice location is listed, or (2) located at an institution that is more than 50 miles from any of the supplier's existing, in-State practice locations, the contractor shall contact the practitioner to verify that this is indeed his or her intention. If the practitioner indicates that he or she never submitted such a request, the contractor shall deny the enrollment/change application and refer the matter to the program safeguard contractor (PSC) or zone program integrity contractor (ZPIC).

E. State Relationships

To the maximum extent possible, and to help ensure that it becomes aware of recent felony convictions of practitioners and owners of health care organizations, the contractor shall establish relationships with appropriate State government entities – such as, but not limited to, Medicaid fraud units, State licensing boards, and criminal divisions – designed to facilitate the flow of felony information from the State to the contractor. For instance, the contractor can request that the State inform it of any new felony convictions of health care practitioners.

15.7.5.2 – Verification of Legalized Status

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

If a physician or non-physician practitioner indicates in Section 2 of his/her Medicare enrollment application (CMS-855I or Internet-based PECOS) that he/she was born in a foreign country, the contractor shall verify that the physician or non-physician practitioner is: (1) a United States citizen; (2) a permanent resident of the United States, or (3) otherwise legally authorized to work in the United States. Note: These

requirements are consistent with the requirements for obtaining a Social Security Number.

If the physician or non-physician practitioner is not eligible to work in the United States, Puerto Rico, or a United States Territory, the contractor shall deny the enrollment application using 42 CFR §424.530(a)(1) as the legal basis.

15.7.6 - Special Verification Procedures for Form CMS-855B, Form CMS-855I and Form CMS-855R Applications

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

A. Reassignment Packages

In situations where an entity wants to simultaneously enroll a group practice, the individual practitioners therein, and to reassign benefits accordingly, the contractor shall adhere to the instructions contained in the scenarios below. During the pre-screening process, the contractor shall examine the incoming forms to see if a reassignment may be involved.

- *Only the CMS-855Rs are submitted - If a brand new group with new practitioners is attempting to enroll but submits only the CMS-855Rs for its group members (i.e., neither the initial CMS-855B nor the initial CMS-855Is were submitted), the contractor may return the applications if the group fails to submit all of the other forms necessary to process the enrollment package within 15 calendar days after receipt of the CMS-855Rs.*

- *Only the CMS-855B is submitted - If a brand new group wants to enroll but submits only the CMS-855B without attaching the CMS-855Is and CMS-855Rs for its group members (i.e., the CMS-855B arrives alone, without the other forms), the contractor may return the application if the group fails to submit all of the other forms necessary to process the enrollment package within 15 calendar days after receipt of the CMS-855B.*

- *Only the CMS-855I is submitted – Suppose an individual: (1) submits only the CMS-855I without attaching the CMS-855B and CMS-855R (i.e., the CMS-855I arrives alone, without the other forms), and (2) indicates on the CMS-855I that he/she will be reassigning all of his/her benefits to the group practice. In this scenario, the contractor may return the application if the applicant fails to submit all of the other forms necessary to process the enrollment package within 15 calendar days after receipt of the CMS-855I.*

In each of the aforementioned situations, the contractor can also return all other forms that were submitted as part of the incomplete enrollment package. For instance, suppose an individual reassigning all of his/her benefits to a group submits his/her CMS-855I on Day 1. The CMS-855B is submitted on Day 15, but no CMS-855R arrives. The contractor can return both the CMS-855B and the CMS-855I. (Note also that the 15-day clock described above begins when the contractor first received part of

the reassignment package; in our example above, the clock started when the contractor received the CMS-855I.)

When applications are returned as described in this section 15.7.6, the contractor shall follow the provisions of section 15.8.1 of this chapter in terms of notification to the provider, no creation of an L & T record in PECOS, etc. The timeliness clocks for these applications only begin when and if the entire enrollment package is submitted within the initial 15-day period.

In situations where an individual will be reassigning part (but not all) of his/her benefits to a group, the contractor shall not return the CMS-855I application if the CMS-855R and the CMS-855B do not arrive. Rather, the contractor shall begin processing the individual's CMS-855I with respect to the practice location for the individual's practice.

B. Other Items

The contractor shall note the following:

- *If an individual is joining a group that was enrolled prior to the CMS-855B (i.e., the group never completed a CMS-855), the contractor shall obtain a CMS-855B from the group. During this timeframe, the contractor shall not withhold any payment from the group. Once the group's application is received, the contractor shall add the new reassignment; if the CMS-855R was not submitted, the contractor shall secure it from the supplier.*

- *If a supplier is changing its tax identification number, the transaction shall be treated as a brand new enrollment as opposed to a change of information. Consequently, the supplier must complete a full CMS-855 application and a new enrollment record must be created in PECOS. (This does not apply to ASCs and portable x-ray suppliers. These entities can submit a TIN change as a change of information unless a CHOW is involved. If the latter is the case, the applicable instructions in sections 15.7.8.2.1 through 15.7.8.2.1.2 of this chapter should be followed.)*

- *If the supplier is adding or changing a practice location and the new location is in another State within the contractor's jurisdiction, the contractor shall ensure that the supplier furnishes all applicable licenses, certifications, etc., for that State. A complete CMS-855 application for the new State is not required, though the contractor shall create a new enrollment record in PECOS for the new State.*

- *All members of a group practice must be entered into PECOS.*

15.7.7 – Special Verification Procedures for Form CMS-855A Applications

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

Unless otherwise stated, all references to the "RO" in sections 15.7.7.1 through 15.7.7.7 of this chapter refer to the RO's survey & certification staff.

15.7.7.1 - Changes of Ownership (CHOWs)

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

Unless specified otherwise, the term "CHOW" - as used in sections 15.7.7.1 through 15.7.7.1.6 of this chapter - includes CHOWs, acquisitions/mergers and consolidations.

Changes of ownership (CHOWs) are officially defined and governed by 42 CFR §489.18 and Publication 100-07, chapter 3, sections 3210 through 3210.5(C). The ROs make the final determination as to whether a CHOW has occurred (unless this function has been delegated).

15.7.7.1.1 - Definitions

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

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

- ***"Standard" CHOW** – This occurs when the CCN number and provider agreement of a provider are transferred to another entity as a result of the latter's purchase of the provider. To illustrate, suppose Entity A is enrolled in Medicare, but Entity B is not. B acquires A. Assuming all regulatory requirements are met, A's provider agreement and CCN number will transfer to B.*

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

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

If the acquisition results in an existing provider having new owners but keeping its existing provider number, the applicant should check the CHOW box in section 1A of the CMS-855A.

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

- ***Consolidations*** *- This occurs when the merger of two or more Medicare-enrolled entities results in the creation of a brand new entity. To illustrate, if Entities A and B decide to combine and, in the process, create a new entity (Entity C), the CCN numbers and provider agreements of both A and B will be eliminated; Entity C will have its own CCN number and provider agreement.*

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

Note that under 42 CFR §489.18(a)(4), the lease of all or part of a provider facility constitutes a change of ownership of the leased portion. If only part of the provider is leased, the original provider agreement remains in effect only with respect to the un-leased portion. (See Pub. 100-07, chapter 3, section 3210.1D (4) for more information.)

15.7.7.1.2 - Determining Whether a CHOW Has Occurred

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

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

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

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

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

15.7.7.1.3 - Processing CHOW Applications

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

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

A. Old Owners

The old owner's CMS-855A CHOW application does not require a recommendation for approval or denial; any recommendations will be based upon the CHOW application received from the new owner.

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

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

Note that an old owner's CMS-855A CHOW application is essentially the equivalent of a CMS-855 voluntary termination submission, as the seller is voluntarily leaving the Medicare program. As such, the contractor shall not require the seller to submit a separate CMS-855 voluntary termination along with its CMS-855A CHOW application.

B. New Owners

If a CMS-855A is not received from the new owner within 14 calendar days of receipt of the old owner's CMS-855A, the contractor shall contact the new owner. If the new owner fails to: (1) submit a CMS-855A and (2) indicate that it accepts assignment of the provider agreement, within 30 calendar days after the contractor contacted it, the

latter shall stop payments unless the sale has not yet taken place per the terms of the sales agreement. Payments to the provider can resume once this information is received and the contractor ascertains that the provider accepts assignment.

C. Order of Processing

To the maximum extent practicable, CMS-855A applications from the old and new owners in a CHOW should be processed as they come in. The contractor should not wait for applications from both the old and new owner to arrive before processing them. However, unless the instructions in this chapter indicate otherwise, the contractor should attempt to send the old and new applications to the State simultaneously, rather than as soon as they are processed. For instance, suppose the old owner submits an application on March 1. The contractor should begin processing the application immediately, without waiting for the arrival of the new owner's application. Yet it should avoid sending the old owner's application to the State until the new owner's application comes in. (For acquisition/mergers and consolidations, the contractor may send in the applications separately, since one number is going away.)

D. Sales and Lease Agreements

The contractor shall abide by the following:

- ***Verification of Terms*** *- The contractor shall determine: (1) whether the information contained in the sales/lease agreement is consistent with that reported on the new owner's CMS-855A (e.g., same names), and (2) whether the terms of the contract indicate that the new owner will assume the provider agreement. In many cases, the sales/lease agreement will not specifically refer to the Medicare provider agreement. Clearly, if the box in section 2F is checked "yes" and the sales/lease agreement either confirms that the new owner will assume the agreement or is relatively silent on the matter, the contractor can proceed as normal. (The RO will obviously make the final decision.) Conversely, if the agreement indicates that the assets and liabilities will not be accepted, the contractor should recommend denial. As discussed above, such matters can be referred to the RO if needed.*

- ***Form of Sales/Lease Agreement*** *- There may be instances where the parties in a CHOW did not sign a "sales" or "lease" agreement in the conventional sense of the term; the parties, for example, may have documented their agreement via a "bill of sale." The contractor may accept this alternative documentation in lieu of a sales/lease agreement so long as the document furnishes clear verification of the terms of the transaction.*

- ***Submission of Final Sales/Lease Agreement*** *- The contractor shall not forward a copy of the application to the State agency until it has received and reviewed the final sales/lease agreement. It need not revalidate the information on the*

CMS-855A even if the data therein may be somewhat outdated by the time the final agreement is received.

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

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

E. CHOWs Involving Subunits and Subtypes

Any subunit that has a separate provider agreement (e.g., HHA subunits) must report its CHOW on a separate CMS-855A. They cannot report the CHOW via the main provider's CMS-855A. If the subunit has a separate CCN number but not a separate provider agreement (e.g., hospital psychiatric unit, HHA branch), the CHOW can be disclosed on the main provider's CMS-855A. This is because the subunit is a practice location of the main provider and not a separately enrolled entity.

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

NOTE: For Medicare purposes, a critical access hospital (CAH) is a separately-recognized provider type. Thus, a general hospital that undergoes a CHOW while converting to a CAH must submit its CMS-855A as an initial enrollment, not as a CHOW.

F. Early Submission of CHOW Application

The CMS-855A CHOW applications may be accepted by the contractor up to 90 calendar days prior to the anticipated date of the proposed ownership change. Any application received more than 3 months in advance of the projected sale date can be returned under section 15.8.1 of this chapter.

G. Unreported CHOW

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

If the contractor learns of the transaction via the receipt of a tie-in notice from the RO, it shall follow the instructions under "Receipt of Tie-In When CMS-855A Not Completed" in section 15.7.7.2 of this chapter.

H. Relocation of Entity

A new owner may propose to relocate the provider concurrent with the CHOW. If the relocation is to a site in a different geographic area serving different clients than previously served and employing different personnel to serve those clients, the contractor shall notify the RO immediately. Unless the RO dictates otherwise, the provider shall - per Pub. 100-07, chapter 3, section 3210.1(B)(5) - treat the transaction as an initial enrollment (and the provider as a new applicant), rather than as an address change of the existing provider.

15.7.7.1.4 - Intervening CHOWs

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

In situations where: (1) the provider submits a CMS-855A initial application or CHOW application and (2) a CMS-855A CHOW application is later submitted but before the contractor has finished processing the first application, the contractor shall notify its Provider Enrollment Operations Group (PEOG) liaison immediately. To illustrate, suppose that the seller (X) and the buyer (Y) in a CHOW submit their respective CMS-855A applications on March 1. On March 30, Y and Z submit CHOW applications as the old and new owners, respectively, in a subsequent CHOW. Assuming that it has not yet finished processing the March 1 applications, the contractor shall immediately refer the matter to its PEOG liaison.

15.7.7.1.5 - EFT Payments and CHOWs

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

In a CHOW, the contractor shall continue to pay the old owner until it receives the tie-in notice from the RO. Hence, any application from the old or new owner to change the EFT account or special payment address to that of the new owner shall be returned in accordance with section 15.8.1 of this chapter. It is ultimately the responsibility of the old and new owners to work out any payment arrangements between themselves while the CHOW is being processed by the contractor and the RO.

15.7.7.1.6 – Pre-Approval Informational Changes

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

A. Seller

If – prior to the issuance of the tie-in notice – the contractor receives from the seller a CMS-855 request to change any of the provider's enrollment data, the contractor shall, per section 15.8.1 of this chapter, return the application to the seller if the information in question involves changing the provider's:

1. EFT or special payment address information to that of the buyer (as described in section 15.7.7.1.5 of this chapter);

2. Practice location or base of operations to that of the buyer;

3. Ownership or managing control to that of the buyer;

4. LBN, TIN, or DBA name to that of the buyer.

All other CMS-855 change requests submitted by the seller can be processed normally.

B. Buyer

If – prior to the issuance of the tie-in notice – the contractor receives from the buyer a CMS-855 request to change any of the provider's existing enrollment information, the contractor shall return the application per section 15.8.1 of this chapter. Until the tie-in is issued, the seller remains the owner of record; hence, the buyer has no standing to submit CMS-855 changes on behalf of the provider.

15.7.7.2 - Tie-In Notices

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

A. General Principles for Tie-In/Tie-out Issuances

Tie-in and tie-out notices (CMS-2007) are generally issued in the following circumstances:

1. *Initial enrollments;*
2. *CHOWs;*
3. *Voluntary terminations;*
4. *Involuntary terminations (e.g., provider no longer meets conditions of participation or coverage) prompted by the State/RO*

With the exception of voluntary and involuntary terminations, each of the transactions described above require a referral and recommendation to the State/RO.

B. CMS-855 Changes of Information

(i). Referrals to State/RO

The following is a list of CMS-855A changes of information that require a recommendation and referral to the State/RO:

- *Addition of OPT extension site;*
- *Addition of hospice satellite*
- *Addition of HHA branch;*
- *Change in type of PPS-exempt unit;*
- *Conversion of a hospital from one type to another (e.g., acute care to psychiatric);*
- *Change in practice location or subunit address in cases where a survey of the new site is required;*
- *Stock transfers*

In these situations, the PECOS record should not be switched to "approved" until the contractor receives notice from the RO that the latter has indeed authorized the change/addition.

(ii). Post-Approval RO Contact Required

Changes that do not mandate a recommendation to the State/RO but do require post-approval correspondence with the RO include:

- *Deletions/Voluntary Terminations of practice locations or subunits;*
- *LBN, TIN, or DBA name changes that do not involve a CHOW;*
- *Address changes that do not require a survey of the new location;*
- *Addition of hospital practice location*

For these transactions, the contractor shall notify the provider via letter, e-mail, or telephone that the change has been made and shall switch the PECOS record to "approved." The contractor shall also notify the State and RO of the changed information (via any mechanism it chooses, including copying the State/RO on the notification letter or e-mail) no later than 10 calendar days after it has completed

processing the transaction. Such notice to the State/RO should specify the type information that is changing.

(iii). All Other Changes of Information

For all CMS-855A change requests not identified in (B)(i) or (B)(ii) above, the contractor shall notify the provider via letter, e-mail, or telephone that the change has been made and shall switch the PECOS record to "approved." The State and RO need not be notified of the change.

(iv). Revalidations, Reactivations and Complete CMS-855 Applications

In situations where the provider submits a: (1) CMS-855A reactivation, (2) CMS-855A revalidation, or (3) full CMS-855A as part of a change of information (i.e., the provider does not have a complete enrollment record in PECOS), the contractor shall make a recommendation to the State/RO and switch the PECOS record to "approval recommended" only if the application contains new/changed data falling within the category of items in (B)(i) above. For instance, if a revalidation application reveals a new hospital psychiatric unit that has never been previously reported to CMS via the CMS-855A, the contractor shall make a recommendation to the State/RO and await the RO's approval before switching the record to "approved." In this situation, the contractor should forward the whole application to the State with a note explaining that the only matter the State/RO needs to consider is the new hospital unit.

If the application contains new/changed data falling within the category of items in (B)(ii) above, the contractor can switch the PECOS record to "approved." It shall also notify the State and RO of the changed information (via any mechanism it chooses, including copying the State/RO on the notification letter or e-mail) no later than 10 calendar days after it has completed processing the transaction.

C. Provider-Specific, Non-CMS-855 Changes

If the contractor receives a tie-in notice for a transaction/change regarding information that is not collected on the CMS-855 application, the contractor obviously need not request the provider to submit a CMS-855 change of information.

D. Involuntary Termination Prompted by State/RO

If the contractor receives a tie-out notice from the RO that involuntarily terminates the provider's participation in the Medicare program on the grounds that the provider no longer meets the conditions of participation, the contractor need not send a letter to the provider notifying the latter that its participation/enrollment in Medicare has been terminated. (The RO will issue such a letter and afford appeal rights.)

E. Miscellaneous Information

Items 1 through 6 below address special procedures related to the contractor's handling of tie-in and tie-out notices.

1. Receipt of Tie-In When CMS-855A Not Completed *- If the contractor receives a tie-in notice from the RO but the provider never completed the necessary CMS-855A paperwork, the contractor shall have the provider complete and submit said paperwork. This applies to initial applications, CHOWs, practice location additions, etc., but does not apply to the cases described in subsection C above.*

2. Delegation to State Agency – *There may be instances when the RO delegates the task of issuing tie-in or tie-out notices to the State agency. The contractor may accept such notices from the State in lieu of those from the RO. However, the contractor should first contact the applicable RO to confirm: (1) that the latter has indeed delegated this function to the State, and (2) the specific transactions (e.g., CHOWs, HHA branch additions) for which this function has been delegated.*

3. Review for Consistency *- When the contractor receives a tie-in notice or approval letter from the RO, it shall review its contents to ensure that the data on the notice/letter matches that on the CMS-855A. If there are discrepancies (e.g., different legal business name, address), the contractor shall contact the applicable RO to determine why the data is different.*

4. Creation of New L & T Record Unnecessary *- The contractor is not required to create a new L & T record in PECOS when the tie-in notice comes in, as the existing record should not be in a final status and can therefore be modified. Simply changing the L & T status is sufficient.*

5. Provider Inquiries – *Once the contractor has made its recommendation for approval to the State/RO, any inquiry the contractor receives from the provider regarding the status of its request for Medicare participation shall be referred to the State or RO.*

6. Timeframes *- So as not to keep the PECOS record in "approval recommended" status interminably, if the contractor does not receive notification of approval from the RO after what it deems to be an excessive amount of time, it may contact the RO to see if such approval is forthcoming.*

15.7.7.2.1 – Processing Tie-In Notices

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

Within 21 calendar days after its receipt of the tie-in or approval notice, the contractor shall complete its processing of said notice. For purposes of this requirement, the term "processing" includes:

1. Entering all relevant data into PECOS;

2. Changing the provider's PECOS record to the appropriate status (e.g., "approved"); and

3. Notifying the provider (via any mechanism the contractor chooses) that it may begin billing.

15.7.7.3 - Out-of-State Practice Locations for Certified Providers
(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

As a general rule, the question of whether a CMS-855A needs to be completed for each State in which the provider performs services depends on three things: (1) State law, (2) the contractor jurisdictions involved, and (3) how the RO(s) wants to handle the situation. Consider the following scenario:

A provider is enrolled in State X and now wants to perform services in State Y.

1. Assume that X & Y are in the same contractor jurisdiction. If State Y requires an entity performing services in Y to be surveyed or the RO says that the provider must sign a separate provider agreement and obtain a separate CCN for its State Y services, the provider must submit an initial CMS-855A application for State Y in order to be a provider in that state. If a separate enrollment is not required, the provider would simply submit a CMS-855A change of information request that adds the out-of-state location.

2. Assume that X & Y are not in the same contractor jurisdiction. In this case, the provider must submit an initial CMS-855A application to the State Y contractor - regardless of whether a separate survey, agreement, or CCN number is needed.

In short, if a provider in one State wishes to perform services in another State and the latter State is serviced by a different contractor, a new enrollment is required with that contractor. If both States are in the same contractor jurisdiction, a CMS-855 initial application or a CMS-855 change of information is necessary; whether an initial application or a change request is required will depend on State law and what the RO says. In either case, the contractor must create a new enrollment record in PECOS – one for each State. (See section 15.10.2 of this chapter for additional guidance.)

15.7.7.4 - State Surveys and the Form CMS-855A
(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

In general, information on the CMS-855A is still considered to be valid notwithstanding a delay in the State survey. However, the provider will be required to submit an updated CMS-855A application to the contractor if:

- *The contractor becomes aware of such a delay;*
- *The delay is the fault of the provider; and*
- *At least 6 months have passed since the contractor sent its recommendation for approval to the State.*

If these criteria are met, the contractor shall send a letter to the provider requesting an updated CMS-855A. The application must contain, at a minimum, any information that is new or has changed since the recommendation for approval was made, as well as a newly-signed certification statement. If no information has changed, the provider may instead submit: (1) a letter on its business letterhead stating as such, and (2) a newly-signed CMS-855A certification statement.

***NOTE:** If the applicant is an HHA, it must resubmit capitalization data as required by section 12 of the CMS-855A irrespective of whether any of the provider's other CMS-855A information has changed. To illustrate, if no CMS-855A data has changed, the HHA must submit the letter, capitalization data and the signed certification statement.*

If the provider fails to furnish the requested information within 60 days, the contractor shall submit a revised letter to the State that recommends denial of the provider's application.

15.7.7.5 - Sole Proprietorships

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

If the provider indicates in section 2B1 of the CMS-855A that he/she is a sole proprietor, the contractor shall note the following:

- *The LBN in section 2B1 should list the person's (the sole proprietor's) legal name;*
- *The TIN in section 2B1 should list the person's SSN;*
- *Section 3 of the CMS-855A must be completed with information about the individual's adverse legal history;*
- *Section 5 of the CMS-855A will not apply unless the person has hired an entity to exercise managerial control over the business (i.e., no owners will be listed in section 5, as the sole owner has already reported his/her personal information in sections 2 and 3).*
- *No owners, partners, or directors/officers need be reported in section 6. However, all managing employees (whether W-2 or not) must be listed.*
- *The sole proprietor may list multiple authorized or delegated officials in section 15 and 16.*

Since most sole proprietorships that complete the CMS-855A will also have an EIN, the contractor shall request from the provider a copy of its CP-575.

15.7.7.6 - Additional Form CMS-855A Processing Instructions
(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

- ***Non-Enrollment Functions and Timeliness*** *– There may be instances where the contractor cannot forward an application to the State until it performs certain non-enrollment functions pertaining to that application (e.g., the reimbursement unit needs to examine patient listing data). The contractor may flip the PECOS status to "approval recommended" prior to the conclusion of this non-enrollment activity, but only if this is the lone remaining activity to be completed. In other words, all enrollment tasks required to be performed under this chapter 15 must have been completed prior to the contractor making its determination.*

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

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

15.7.7.7 - Jurisdictional Issues
(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

A. Audit and Claims Intermediaries

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

In situations where the audit and claims intermediaries differ, the audit contractor shall process all changes of information, including all EFT changes. The audit contractor shall notify the applicant during the initial enrollment process that all future changes of information must be sent to the audit contractor, not the claims contractor. (Quite often, a provider will submit an EFT change request to the claims contractor because the latter processes the provider's claims.) If the provider inadvertently sends a change of information request (or, for that matter, an initial enrollment) to the claims contractor, the latter shall return the application per section 15.8.1 of this chapter.

Once the audit contractor finishes processing the initial enrollment application, change of information, voluntary termination, or any other CMS-855 transaction, it shall e-

mail a notification of the applicable CMS-855 transaction to the claims contractor that information has been updated in PECOS. Pertinent identifying information such as the Provider Name, CCN, NPI, and ERID should be included on the e-mail notification. Any supporting documentation that may contain Personal Health Information (PHI) or Personally Identifiable Information (PII) such as Electronic Funds Transfer (EFT) may still be faxed to the claims contractor.

Upon receipt of the e-mail notification, the claims contractor shall be responsible for accessing PECOS and reviewing the enrollment record ID to see what has changed and update its records accordingly.

The audit contractor shall be responsible for keeping the original copies on the CMS 855 paperwork and supporting documentation.

Moreover, in situations where the audit contractor is different from the claims contractor, the audit contractor shall e-mail a copy of all tie-in and tie-out notices it receives to the claims contractor. For instance, if the audit contractor receives a tie-in notice signifying that a provider's request for Medicare participation has been approved, the audit contractor shall send an e-mail copy to the claims contractor. This is to ensure that the claims contractor is fully aware of the RO's action, as some ROs may only send copies of tie-in and tie-out notices to the audit contractor. If the audit contractor chooses, it can simply contact the claims contractor by phone or e-mail and ask if the latter received the tie-in notice.

Again, it is imperative that audit and claims intermediaries effectively communicate and coordinate with each other in all payment-related and program integrity matters involving the provider.

B. Provider Nomination

With respect to issues regarding provider nomination and changes of intermediaries, the contractor shall adhere to the instructions in Pub. 100-04, chapter 1, sections 20 through 20.5.1.

If a contractor receives a request from a provider to change its existing contractor, it shall refer the provider to the RO contact person responsible for contractor assignments.

15.7.8 – Special Verification Procedures for Enrolling Independent CLIA Labs, Ambulatory Surgical Centers (ASCs), and Portable X-ray Suppliers

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

Unless otherwise stated, all references to the "RO" in sections 15.7.8.2 through 15.7.8.5 of this chapter refer to the RO's survey & certification staff.

15.7.8.1 - CLIA Labs
(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

Labs that are "integrated" into an existing provider or supplier do not require a separate CMS-855B enrollment. "Integrated" labs are typically those that have exactly the same ownership and physical location as another enrolled supplier or provider. (Common examples include: (1) hospital labs and (2) a lab at a physician's office.) If a lab is deemed as "integrated," the parent provider shall identity the lab as a practice location in section 4 of its CMS-855.

If the lab is not "integrated," the lab must enroll as an independent CLIA lab via the CMS-855B application. The contractor shall advise the lab that it must contact the applicable CLIA office; the lab cannot be enrolled until it receives a CLIA number. The contractor shall also ensure that the lab has furnished a notarized or certified true copy of the CLIA certificate or State license.

Labs that do not plan to participate in the Medicare program must be directed to the applicable CLIA office.

For more information on the enrollment of CLIA labs, refer to section 15.4.2.2 of this chapter.

15.7.8.2 - ASCs and Portable X-ray Suppliers (PXRS)
(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

Unlike other supplier types whose applications are processed by contractors, ASCs and PXRSs must receive a State survey and formal RO approval before they can be enrolled in Medicare. As such, once it finishes reviewing the supplier's application the contractor can only make a recommendation for approval or denial to the State. The contractor shall not enroll the supplier unless and until it receives a document or other notification from the RO stating that the supplier has met all of the qualifications needed to obtain Medicare billing privileges. (This document is usually an approval letter or "tie-in notice.") Upon receipt of the tie-in notice or approval letter from the RO, the contractor shall enroll the ASC or PXRS effective on the date shown on the notice. This is the date from which the supplier can bill for services.

15.7.8.2.1 - ASC/PXRS Changes of Ownership (CHOWs)
(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

Though ASCs and PXRSs are not specifically mentioned in 42 CFR §489.18, CMS generally applies the change of ownership (CHOW) provisions of said regulation to these two supplier types. CHOWs involving ASCs and PXRSs are therefore handled in accordance with the principles of 42 CFR §489.18 and Publication 100-07, chapter 3, sections 3210 through 3210.5(C). Note that the ROs make the final determination as to whether a CHOW has occurred (unless this function has been delegated).

As discussed in more detail in sections 15.4.2.1 and 15.4.2.5 of this chapter, an ASC must sign a supplier agreement with Medicare prior to enrollment; PXRSs have no such requirement. The ROs may therefore handle CHOWs involving ASCs and PXRSs differently. To alleviate confusion and to ensure consistency, however, contractors will – unless stated otherwise – handle the CMS-855B processing of ASC CHOWs in the same manner as PXRS CHOWs.

15.7.8.2.1.1 - Determining Whether a CHOW Has Occurred

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

A. Review of Sales Agreement

If the "Change of Ownership" box in section 1B of the CMS-855B is checked, the contractor shall ensure that the entire application is completed and that the supplier submits a copy of the sales agreement. The contractor shall review the sales agreement to determine whether:

1. The ownership change qualifies as a CHOW under the principles of 42 CFR §489.18 and Pub. 100-07, chapter 3, section 3210.1D;

2. Its terms indicate that the new owner will be accepting assignment of the Medicare assets and liabilities of the old owner;

3. The information contained in the agreement is consistent with that reported on the new owner's CMS-855B (e.g., same names)

If the sales agreement is unclear as to issues 1 and 2 above, the contractor shall request clarifying information from the supplier. (Note that some sales agreements may fail to specifically refer to Medicare supplier agreements, assets, and/or liabilities, therefore requiring a close review of the sales agreement in its totality.) The information shall be in the form of additional legal documentation or a letter. If the clarification – for whatever reason - requires an update to the supplier's CMS-855B application, the contractor shall request the submission of said update. In addition, if the contractor discovers discrepancies between the data in the sales agreement and that on the CMS-855B (issue 3 above), the contractor shall seek clarifying information and, if necessary, obtain an updated CMS-855B.

In reviewing the application and the sales agreement, the contractor shall keep in mind the following:

- *There may be instances where the parties in a CHOW did not sign a "sales agreement" in the conventional sense of the term; the parties, for example, may have documented their agreement in a "bill of sale." The contractor may accept this alternative documentation in lieu of a sales agreement so long as the document furnishes clear verification of the terms of the transaction.*

- *While a CHOW is usually accompanied by a TIN change, this is not always the case; there may be a few instances where the TIN remains the same. Conversely, there may be cases where a supplier is changing its TIN but not its ownership. So while a change of TIN (or lack thereof) is evidence that a CHOW has or has not occurred, it is not the most important factor; rather, the change in the provider's ownership structure is.*

- *CMS-855B CHOW applications may be accepted by the contractor up to 90 calendar days prior to the anticipated date of the proposed ownership change. Any application received more than 3 months in advance of the projected sale date shall be returned under section 15.8.1 of this chapter.*

- *On occasion, an ASC or PXRS may submit a CMS-855B change of information to report a large-scale stock transfer or other significant ownership change that the supplier does not believe qualifies as a CHOW. If the contractor has any reason to suspect that the transaction in question may indeed be a CHOW, it shall request clarifying information (e.g., copy of the stock transfer agreement).*

If – after performing the necessary research – the contractor remains unsure as to whether a CHOW has occurred and/or whether the new owner is accepting assignment, the contractor may refer the matter to the RO for guidance. Such referrals to the RO should only be made if the contractor is truly uncertain as to whether a CHOW and/or acceptance of assignment has taken place and should not be made as a matter of course. A RO CHOW determination is usually not required prior to the contractor making its recommendation.

B. Processing Steps

After performing the steps identified in subsection (A) above, the contractor shall abide by the following:

1. If the contractor believes that a CHOW has occurred but the new owner is not accepting the assets and liabilities of the old owner, the contractor shall treat the ASC/PXRS as a brand new supplier. It shall notify the ASC/PXRS that it must submit: (1) a CMS-855B voluntary termination to terminate the "old" facility, and (2) a CMS-855B initial enrollment for the "new" facility.

2. If the contractor believes that a CHOW has taken place and that the new owner is accepting the old owner's assets and liabilities, it shall process the application normally and make a recommendation for approval/denial to the State (with a cc: to the RO). If the valid CHOW/acceptance of assignment was accompanied by a change in TIN, the transaction must be treated as a CHOW notwithstanding the general rule that a TIN change constitutes an initial enrollment. In other words, the reporting rules regarding CHOWs/assignments in this particular situation take precedence over the "change of TIN" principle.

3. If the contractor believes that a CHOW has not occurred and that the transaction merely represents an ownership change (e.g., minor stock transfer) that does not qualify as a 42 CFR §489.18-type CHOW, the transaction must be reported as a change of information. The only exception to this is if the change of information was accompanied by a change of TIN, in which case the supplier must enroll as a new entity.

Note that it is not uncommon for a supplier to undergo a financial or administrative change that it considers to be a CHOW but in actuality does not meet the regulatory definition identified in §489.18.

In scenario 2 above, the contractor shall not forward a copy of the CHOW application to the State agency until it has received and reviewed the final sales agreement. (In some cases, the supplier may submit an interim sales agreement with its application; this is acceptable, so long as it submits the final agreement in accordance with these instructions.) If the final sales agreement is not submitted within 90 days after the contractor's receipt of the new owner's application, the contractor shall reject the application. Though the contractor must wait until the 90th day to reject the application, the contractor may do so regardless of how many times it contacted the new owner or what type of responses (short of the actual receipt of the sales agreement) were obtained.

C. CHOWs and Address Changes

A new owner may propose to relocate the supplier concurrent with a CHOW. If the relocation is to a site in a different geographic area serving different clients than previously served and employing different personnel to serve those clients, the contractor shall notify the RO immediately. Unless the RO dictates otherwise, the supplier shall - per Pub. 100-7, chapter 3, section 3210.1(B)(5) - treat the transaction as an initial enrollment (and the supplier as a new applicant), rather than as an address change of the existing supplier.

15.7.8.2.1.2 - EFT Payments and CHOWs

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

In a CHOW, the contractor shall continue to pay the old owner until it receives the tie-in/approval notice from the RO. Hence, any application from the old or new owner to change the EFT account or special payment address to that of the new owner shall be returned in accordance with section 15.8.1 of this chapter. It is ultimately the responsibility of the old and new owners to work out any payment arrangements between themselves while the CHOW is being processed by the contractor and the RO.

If – pursuant to the CHOW – the seller submits a CMS-855B voluntary termination, the contractor shall contact and explain to the seller that the ASC/PXRS will not receive any payments until the RO approves the CHOW. (This is because, as explained above, payments must be sent to the seller until the tie-in/approval letter is sent). If the seller insists that its application be processed, the contractor shall process said termination;

however, it shall first notify the facility/new owner and explain that payments will cease once the seller's termination is effective. In fact, it is highly recommended that, upon receipt of a CMS-855B CHOW application, the contractor contact the supplier to notify it of the payment rule identified in the previous paragraph.

15.7.8.3 - ASC/PXRS Tie-In Notices

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

(For purposes of this section 15.7.8.3, the terms "tie-in notices" and approval letters will be collectively referred to as tie-in notices. "Tie-out notices" are notices from the RO to the contractor that, in effect, state that the supplier's billing number, Medicare enrollment, practice location, etc., should be terminated.)

A. General Principles for Tie-in/Tie-out Issuances

Tie-in and tie-out notices are generally issued in the following circumstances:

1. *Initial enrollments;*

2. *CHOWs;*

3. *Voluntary terminations;*

4. *Involuntary terminations (e.g., supplier no longer meets conditions of coverage) prompted by the State/RO.*

With the exception of voluntary and involuntary terminations, each of the transactions described above require a referral and recommendation to the State/RO.

B. CMS-855B Changes of Information

(i). Referrals to State/RO

The following is a list of transactions that require a recommendation and referral to the State/RO:

- *Addition of practice location;*

- *Stock transfers;*

- *Change in practice location or subunit address in cases where a survey of the new site is required*

In these situations, the PECOS record should not be switched to "approved" until the contractor receives notice from the RO that the latter has indeed authorized the change/addition.

(ii). Post-Approval RO Contact Required

Changes that do not mandate a recommendation to the State/RO but do require post-approval correspondence with the RO include:

- *Deletions/voluntary terminations of practice locations or subunits;*
- *LBN, TIN, or DBA name changes that do not involve a CHOW;*
- *Address changes that do not require a survey of the new location;*

For these transactions, the contractor shall notify the supplier via letter, e-mail, or telephone that the change has been made and shall switch the PECOS record to "approved." The contractor shall also notify the State and RO of the changed information (via any mechanism it chooses, including copying the State/RO on the notification letter or e-mail) no later than 10 calendar days after it has completed processing the transaction. Such notice to the State/RO should specify the type of information that is changing.

(iii). All Other Changes of Information

For all CMS-855B change requests not identified in (i) or (ii) above, the contractor shall notify the supplier via letter, e-mail, or telephone that the change has been made and shall switch the PECOS record to "approved." The State and RO need not be notified of the change.

(iv). Revalidations, Reactivations and Complete CMS-855 Applications

In situations where the provider submits a: (1) CMS-855B reactivation, (2) CMS-855B revalidation, or (3) full CMS-855B as part of a change of information (i.e., the supplier does not have a complete enrollment record in PECOS), the contractor shall make a recommendation to the State/RO and switch the record to "approval recommended" only if the application contains new/changed data falling within the category of items in (i) above. For instance, if a revalidation application reveals a new practice location that has never been previously reported to CMS via the CMS-855B, the contractor shall make a recommendation to the State/RO and await the RO's approval before switching the record to "approved." In this situation, the contractor should forward the whole application to the State with a note explaining that the only matter the State/RO needs to consider is the new location.

If the application contains changed data falling within the category of items in (ii) above, the contractor can switch the PECOS record to "approved." The contractor shall also notify the State and RO of the changed information (via any mechanism it chooses, including copying the State/RO on the notification letter or e-mail) no later than 10 days after it has completed processing the transaction.

C. Supplier-Specific, Non-CMS-855 Changes

If the contractor receives a tie-in notice for a transaction/change regarding information that is not collected on the CMS-855B application, the contractor obviously need not request the supplier to submit a CMS-855B change of information.

D. Involuntary Termination Prompted by State/RO

If the contractor receives a tie-out notice from the RO that involuntarily terminates the supplier's participation in the Medicare program on the grounds that the supplier no longer meets the conditions of coverage, the contractor need not send a letter to the supplier notifying the latter that its participation/enrollment in Medicare has been terminated. The RO will issue such a letter and afford appeal rights.

E. Miscellaneous Information

Items 1 through 6 below address special procedures related to the contractor's handling of tie-in and tie-out notices.

***1. Receipt of Tie-In When CMS-855B Not Completed** - If the contractor receives a tie-in notice from the RO but the supplier never completed the necessary CMS-855B paperwork, the contractor shall have the supplier complete and submit said paperwork. This applies to initial applications, CHOWs, practice location additions, etc., but does not apply to the cases described in subsection C above.*

***2. Delegation to State Agency –** There may be instances when the RO delegates the task of issuing tie-in or tie-out notices to the State agency. The contractor may accept such notices from the State in lieu of those from the RO. However, the contractor should first contact the applicable RO to confirm: (1) that the latter has indeed delegated this function to the State, and (2) the specific transactions (e.g., CHOWs, site additions) for which this function has been delegated.*

***3. Review for Consistency** - When the contractor receives a tie-in notice or approval letter from the RO, it shall review its contents to ensure that the data on the notice/letter matches that on the CMS-855B. If there are discrepancies (e.g., different legal business name, address), the contractor shall contact the applicable RO to determine why the data is different.*

***4. Creation of New L & T Record Unnecessary** - The contractor is not required to create a new L & T record in PECOS when the tie-in notice comes in, as the existing record should not be in a final status and can therefore be modified. Simply changing the L & T status is sufficient.*

***5. Provider Inquiries -** Once the contractor has made its recommendation for approval to the State/RO, any inquiry the contractor receives from the provider regarding the status of its request for Medicare participation shall be referred to the State or RO.*

6. Timeframes - *So as not to keep the PECOS record in "approval recommended" status interminably, if the contractor does not receive notification of approval from the RO after what it deems to be an excessive amount of time, it may contact the RO to see if such approval is forthcoming.*

15.7.8.3.1 – Processing Tie-In Notices

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

Within 21 calendar days after its receipt of the tie-in or approval notice, the contractor shall complete its processing of said notice. For purposes of this requirement, the term "processing" includes:

1. Entering all relevant data into PECOS

2. Changing the provider's record to the appropriate status (e.g., "approved")

3. Notifying the provider (via any mechanism the contractor chooses) that it may begin billing.

15.7.8.4 - Out-of-State Practice Locations for Certified Suppliers

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

As a general rule, the question of whether a CMS-855B needs to be completed for each State in which the certified supplier performs services depends on three things: (1) State law, (2) the contractor jurisdictions involved, and (3) how the RO(s) wants to handle the situation. Consider the following scenario:

A supplier is enrolled in State X and now wants to perform services in State Y:

1. Assume that X & Y are in the same contractor jurisdiction. If State Y requires an entity performing services in Y to be surveyed or if the RO says that the supplier must sign a separate supplier agreement, the supplier must submit an initial CMS-855B application for State Y in order to be a provider in that state. If a separate enrollment is not required, the supplier can simply submit a CMS-855B change of information request that adds the out-of-state location.

2. Assume that States X & Y are not in the same contractor jurisdiction. Here, the supplier must submit an initial CMS-855B application to the State Y contractor - irrespective of whether a separate survey or agreement is needed.

In short, if a certified supplier wants to perform services in another State that is serviced by another contractor, a new enrollment with that contractor is required. If both States are in the same contractor jurisdiction, a CMS-855B initial application or a CMS-855B change of information will be necessary; whether an initial enrollment or a change request is required will depend on State law and what the RO says. In either case, the contractor must create a new enrollment record in PECOS – one for each State. (See section 15.10.2 of this chapter for additional guidance.)

15.7.8.5 - State Surveys and the Form CMS-855B

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

A. Delay in State Survey

In general, information on the CMS-855B is still considered to be valid notwithstanding a delay in the State survey. However, the supplier will be required to submit an updated CMS-855B application to the contractor if:

- *The contractor becomes aware of such a delay;*
- *The delay is the fault of the supplier; and*
- *At least 6 months have passed since the contractor sent its recommendation for approval to the State.*

If these criteria are met, the contractor shall send a letter to the supplier requesting an updated CMS-855B. The application must contain, at a minimum, any information that is new or has changed since the recommendation for approval was made, as well as a newly-signed certification statement. If no information has changed, the supplier may instead submit: (1) a letter on its business letterhead stating as such, and (2) a newly-signed CMS-855B certification statement.

If the supplier fails to furnish the requested information within 60 calendar days, the contractor shall submit a revised letter to the State that recommends denial of the supplier's application.

B. Future Effective Dates

In situations where the contractor cannot enter effective dates into PECOS because the supplier, its practice location, etc., is not yet established, the contractor may use the authorized official's date of signature as the temporary effective date. Once the provider and actual effective date is established (e.g., the tie-in notice is received), the contractor shall go into PECOS and change the effective date.

15.9 – Application Approvals

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

15.9.1 - Non-Certified Suppliers and Individual Practitioners

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

Medicare contractors, including A/B MACs and the NSC, shall notify all suppliers regarding the disposition of their CMS-855 enrollment application. If the contractor approves a supplier's enrollment (except for ASCs and PXRSs), it shall notify the applicant via letter that the enrollment has been approved. The letter shall include the

NPI by which the supplier will bill the Medicare program and the Provider Transaction Access Number (PTAN) that has been assigned to the supplier as an identifier for inquiries.

The approval letter should provide instructions on how suppliers should use the assigned PTAN whenever they use the contractor interactive voice response (IVR) system for inquires concerning claims status, beneficiary eligibility, check status or other supplier-related IVR transactions. CR 5061 and CR 5089 provide further guidance on the issuance and use of the PTAN.

In addition to instructing suppliers to use their NPI on electronic claim submissions, the contractor shall include language reminding suppliers to update their NPPES record whenever their information changes.

For claims submitted by physicians and non-physicians prior to the date of enrollment, the contractor shall follow the instructions in Pub. 100-04, chapter 1, section 70, with respect to the claim filing limit. Payments cannot be made for services furnished prior to the date the applicant is appropriately licensed. For initial enrollment, the contractor should use the date that the supplier started practicing at the practice location as the date it can begin submitting claims.

15.9.2 - Certified Providers and Certified Suppliers

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

(This section only applies to: (1) contractors when processing initial CMS-855A applications or CHOW, acquisition/merger, or consolidation applications submitted by the new owner; and (2) contractors when processing initial ASCs and PXRs applications.)

Once the contractor has completed its review of the provider or supplier's application and has decided to recommend approval, the contractor shall send a letter of recommendation for approval to the applicable State agency, with a copy going to the RO's survey and certification unit. (For those provider types that do not require a State survey, such as FQHCs, the letter can be sent directly to the RO.) The recommendation letter shall be written (not e-mailed) and, at a minimum, contain the following information:

- *Supplier/Provider NPI Number;*
- *CCN Number (if available);*
- *Type of enrollment transaction (CHOW, initial enrollment, branch addition, etc.);*
- *Contractor Number;*
- *Contractor Contact Name;*

- *Contractor Contact Phone Number;*

- *Date Application Recommended for Approval;*

- *An explanation of any special circumstances, findings, or other information that either the State or the RO should know about.*

The contractor shall also:

- *Send a photocopy (not the original) of the final completed CMS-855 to the State agency, along with all updated CMS-855 pages, explanatory data, documentation, correspondence, final sales agreements, etc. The photocopied CMS-855 should be sent in the same package as the recommendation letter.*

The contractor shall not send a copy of the CMS-855 to the RO unless the latter specifically requests it or if the transaction in question is one for which State involvement is unnecessary.

- *Notify the applicant that the contractor has completed its initial review of the application. The notification can be furnished orally or in writing, and shall advise the applicant of the next steps in the enrollment process (e.g., site visit, survey). The contractor may, but is by no means required to, send a copy of its recommendation letter to the provider as a means of satisfying this requirement. However, the contractor should not send a copy to the provider if the recommendation letter contains sensitive information. In addition, when notifying the provider that the review is finished, the contractor is under no obligation to inform the provider as to the contents of the recommendation (i.e., approval or denial).*

- *Inform the applicant that it could take 6 to 9 months (or longer) for the provider or supplier to obtain its billing number. (In the case of a CHOW, the contractor shall specify that CMS cannot send payments to the new owner until the tie-in notice is issued.) This can be done at any time prior to, or in conjunction with, the notification to the provider of the completion of its review of the application. The contractor may notify the applicant of the phone numbers and e-mail addresses of the applicable State agency and RO that will be handling the survey and certification process from that point forward; the applicant shall also be instructed that all questions related to this process shall be directed to the State agency and/or RO.*

15.9.3 - Approval of DMEPOS Suppliers

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

As stated in 42 CFR §424.57(b), a DMEPOS supplier must, among other things, meet the following conditions to be eligible to receive payment for a Medicare-covered item:

- *The supplier has submitted a completed CMS-855S, including all supporting documentation, to the NSC; and*

- *The item was furnished on or after the date the NSC issued to the supplier a DMEPOS supplier number conveying Medicare billing privileges.*

The date identified in the previous bullet represents the "date of approval."

15.10 – Changes of Information and Voluntary Terminations
(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

Unless indicated otherwise, the instructions in sections 15.10.1 through 15.10.3 of this chapter apply to Part A and Part B enrollments.

15.10.1 – General Procedures
(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

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

The provider shall furnish the changed data in the applicable section of the form and sign and date the certification statement. In accordance with 42 CFR §424.516(d) and (e), the timeframes for providers to report changes in their CMS-855 information are as follows:

A. For physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse-midwives; clinical social workers; clinical psychologists; registered dietitians or nutrition professionals; and organizations (e.g., group practices) consisting of any of the categories of individuals identified in this paragraph.): The following changes must be reported within 30 days:

- *A change of ownership*
- *A final adverse action*
- *A change in practice location*

All other informational changes involving the providers listed in this section 15.10.1(A) must be reported within 90 days.

B. All providers and suppliers other than: (1) those listed in section 15.10.1(A); (2) DMEPOS suppliers; and (3) IDTFs: Any change of ownership, including a change in an authorized or delegated official, must be reported within 30 days. All other informational changes involving the providers listed in this section 15.10.1(B) must be reported within 90 days.

The reporting requirements for IDTFs can be found in 42 CFR 410.33(g)(2) and in section 15.5.19.1 of this chapter. Reporting requirements for DMEPOS suppliers can be found at 42 CFR 424.57(c)(2))

In addition:

- ***Unsolicited Additional Information*** *- Any new or changed information submitted by a provider prior to the date the contractor finishes processing a previously submitted change request is considered to be an update to that change request. It is not considered to be a separate change of information. To illustrate, suppose a provider submits a change request. On the 24th day, it submits additional information that it wants to change. Because the contractor has not finished processing the first change request, it should – for processing purposes – treat the data in the second change request as being part of the first one.*

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

- ***Application Signatures*** *- If the signer has never been reported in section 6 of the CMS-855, section 6 must be completed in full with information about the individual. The contractor shall check the individual against all applicable databases and note in the enrollment file that this task was performed. This policy applies regardless of whether the provider already has a CMS-855 on file.*

Notifications *– For changes of information that do not require RO approval (e.g., CMS-855I changes, CMS-855B changes not involving ASCs or PXRSs, minor CMS-855A changes), the contractor shall furnish written, e-mail, or telephonic confirmation to the provider that the change has been made. Document (per section 15.7.3 of this chapter) in the file the date and time the confirmation was made. If, however, the transaction only involves an area code/ZIP Code change, it is not necessary to send confirmation to the provider that the change has been processed.*

15.10.1.1 – Changes of Information and Complete Form CMS-855 Applications

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

A provider must submit a complete CMS-855 application if it: (1) submits any change request, and (2) does not have an established enrollment record in PECOS. (For purposes of this requirement, the term "change request" includes EFT changes.) It is immaterial: (1) whether the provider, bank, or other party (e.g., change in bank name via merger; local government changes the street name) was responsible for triggering the changed data, or (2) the signer of the change request or EFT form already has a signature on file with the contractor.

If the contractor receives a change request from a provider that is not in PECOS, the contractor shall not return the application/change request. It shall simply develop for the entire application in accordance with the procedures described in section 15.7.2.2 of this chapter; the contractor, in other words, shall treat the transaction as a request

for additional information. Consistent with existing policies for requesting additional data, the provider has 30 calendar days from the date of the contractor's request to furnish the entire CMS-855 application. During this period, the contractor should "hold" (i.e., not process) the change request until the entire application arrives; no L & T record shall be created in PECOS at this point.

If the provider fails to submit a complete application within the aforementioned 30-day period, the contractor shall abide by the instructions in section 15.10.1.2 of this chapter.

If the provider does submit the application, the contractor shall process it in full accordance with all of the instructions in this chapter. This includes:

- *Processing the complete application within 60 calendar days of receipt. Assume the contractor received the change request on March 1. It requested a complete application from the provider on March 10 and received it on April 1. The contractor in this scenario has until June 1 to process the complete CMS-855.*

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

Creating an L & T record and enrollment record in PECOS prior to approving the change request. (This is an exception to the general rule that an L & T record must be created no later than 20 calendar days after the contractor received the application.) The transaction should be treated as an initial enrollment in PECOS; internally, the contractor shall treat it as a change of information. As the completed application will presumably incorporate the changed data reported on the initial CMS-855 change request, the contractor shall not take two separate counts (one initial and one change request) for the transaction.

15.10.1.2 - Incomplete or Unverifiable Changes of Information

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

Certain changes of information cannot be processed to completion: (1) due to the provider's failure to furnish requested clarifying data, (2) because the information on the application cannot be appropriately verified, or (3) the provider does not have an established enrollment record in PECOS and fails to submit a complete CMS-855 in response to the contractor's request. In such cases, the contractor shall abide by the instructions in this section 15.10.1.2.

A. Provider is in PECOS

Assume that a provider submits a CMS-855 change of information and: (1) fails to timely respond to the contractor's request for additional or clarifying information, or

(2) the contractor is otherwise unable to validate the new information. In this circumstance, the contractor obviously shall reject the change request in accordance with section 15.8.2 of this chapter; however, the contractor shall also deactivate the provider's Medicare billing privileges if the information in question is of such materiality that the contractor cannot determine whether the provider still meets all applicable requirements for maintaining enrollment in the Medicare program. (For instance, if the data involves a change in the provider's lone practice location and the contractor cannot verify the validity of the new site, this clearly raises questions as to the provider's continued compliance with Medicare requirements.) Note that the deactivation letter can, if the contractor wishes, be combined with the rejection notice into a single letter.

B. Provider is Not in PECOS

As stated in sections 15.10.1.1 and 15.11 of this chapter, if a provider does not have an established enrollment record in PECOS and wants to change any of its existing enrollment of EFT information, it must submit a complete Medicare enrollment application before the contractor can effectuate the change. If the provider refuses to or otherwise fails to submit the completed form within the applicable 30-day period, the contractor shall request that the provider revalidate its Medicare enrollment information per 42 CFR § 424.515.

15.10.2 - Special Instructions for Certified Providers, ASCs, and Portable X-ray Suppliers

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

A. Timeframe for RO Approval

In situations where RO approval of the change of information is required, it is strongly recommended that the contractor advise the provider that it may take 6 months (or longer) for the request to be approved. The manner and timing in which this information is relayed lies solely within the contractor's discretion.

B. Post-Recommendation Changes

If an applicant submits a change request after the contractor makes a recommendation on the provider's initial CMS-855 application but before the RO issues a tie-in/approval notice, the contractor shall process the newly-submitted data as a separate change of information; it shall not take the changed information/corrected pages and, immediately upon receipt, send them directly to the State/RO to be incorporated into the existing application. The contractor, however, need not enter the change request into PECOS until the tie-in notice is issued.

In entering the change request into PECOS, the contractor shall use the date it received the change request in its mailroom as the actual receipt date in PECOS; the date the tie-in notice was issued shall not be used. The contractor shall explain the situation in the "Comments" section in PECOS and in the provider file.

C. 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.*

15.10.3 – Voluntary Terminations

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

Voluntary terminations shall be processed in accordance with the timeframes in section 6.2 et al. of this chapter (e.g., 80 percent within 45 calendar days).

If the termination involves a certified provider, ASC, or PXRSs, the contractor may terminate the entity without making a recommendation to the State and RO. No later than 3 business days after the contractor has finished processing the termination, however, it shall notify the State and RO thereof; said notification can be made via letter, e-mail, or fax.

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

15.11 – Electronic Fund Transfers (EFT)

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

If a provider does not have an established enrollment record in PECOS and wants to change any of its EFT information (e.g., bank routing number), it must submit a complete CMS-855 form before the contractor can effectuate the change. It is immaterial whether: (1) the provider or the bank (e.g., change in bank name via merger) was responsible for triggering the changed data or (2) the signer of the CMS-588 already has a signature on file with the contractor. (For more information on how the contractor should handle this type of situation, see section 15.10.1.1 of this chapter.)

As stated in 42 CFR §424.510(d)(2)(iv) and §424.510(e), all providers (including Federal, State and local governments) entering the Medicare program for the first time must use EFT in order to receive payments. Moreover, any provider not currently on EFT that: (1) submits any change to its existing enrollment data or (2) submits a

revalidation application, must also submit a CMS-588 form and thereafter receive payments via EFT.

Under 42 CFR §424.510(d)(2)(iv) and §424.510(e), if a provider is already receiving payments via EFT and is located in a jurisdiction that is undergoing a change of Medicare contractors, the provider must continue to receive EFT payments and, to this end, must also submit a new CMS-588 form that authorizes the new contractor to make payments to the provider's EFT account. The contractor shall process the CMS-588 in this situation as it would in any other scenario.

In addition:

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

2. Verification *- The contractor shall verify that all initial EFT applications and EFT changes comply with Pub. 100-04, chapter 1, section 30.2.5.*

3. Sent to the Wrong Unit *- If a provider 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 ultimately responsible for processing EFT changes. As such, while it may send the original EFT form back to the recipient unit, the enrollment unit shall keep a copy of the EFT form and append it to the provider's CMS-855 in the file.*

4. CMS 588 Changes and PECOS – *In situations where the only data the provider is changing is on the CMS-588 (i.e., no data is changing on the CMS-855), the contractor shall process the EFT change using the timeframes cited in section 15.6.2 et al. of this chapter; moreover, and notwithstanding any instruction to the contrary in this chapter, the contractor shall create an L & T record using the "Other" button in PECOS.*

5. Comparing Signatures *- If the contractor receives an EFT change request, it shall compare the signature thereon with the same official's signature on file to ensure that it is indeed the same person. (See also Pub. 100-04, chapter 24, section 40.7) If the person's signature is not already on file, the contractor shall request that he/she complete section 6 of the CMS-855 and furnish his/her signature in section 15 or 16 of the CMS-855. (This shall be treated as part of the EFT change request for purposes of timeliness and reporting.)*

6. Bankruptcies and Garnishments *– If the contractor receives a copy of a court order to send payments to a party other than the provider, it shall contact the applicable RO's Office of General Counsel. (In general, all court orders take precedence over the instructions in this chapter.)*

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

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

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

10. Chain Organizations *- Per 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 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 CMS- 588s must be submitted. If any of the chain providers have never completed a CMS-855 before, they must do so at that time.*

11. Audit and Claims Intermediaries – *In cases where the provider's audit and claims intermediaries differ, the contractor shall not reject the provider's CMS-588 form if the provider listed the claims contractor – rather than the audit contractor – thereon.*

15.12 – Reserved for Future Use

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

15.13 – Reserved for Future Use

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

15.14 – Special Processing Situations

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

15.14.1 – Non-CMS-855 Enrollment Activities

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

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

- *EFT agreements (CMS-588) submitted alone;*
- *"Do Not Forward" issues;*
- *Par agreements (CMS-460);*
- *Returned remittance notices;*
- *Informational letters received from other contractors;*
- *Diabetes self-management notices;*
- *Verification of new billing services;*
- *Paramedic intercept contracts;*
- *1099 issues that need to be resolved.*

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

15.14.2 – Contractor Communications

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

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

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

The requesting contractor may notify the owning contractor via fax of the need to update/change/correct information in a provider's PECOS record. When the

requesting contractor notifies the owning contractor of the needed update/change/correction, the following information must be furnished:

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

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

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

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

15.14.3 – Provider-Based

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

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

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

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

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

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

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

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

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

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

A non-participating emergency hospital or DOD 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.

A VA hospital must complete and submit a CMS-855A enrollment application and CMS-588 EFT form if it wishes to bill Medicare for any non-emergency services performed. Emergency VA services, however, do not require the completion of a CMS-855 or CMS-588 form.

When creating a PECOS enrollment record for one of these providers, the contractor shall select a Provider Type of "Other" and then enter the type of hospital in question.

15.14.5 – Form CMS-855B Applications Submitted by Hospitals

A. Group Practices

The contractor shall review all CMS-855B applications for hospital-owned clinics/physician practices and department billings. The contractor shall contact the applicant to determine if the latter will be billing any of these 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 CMS-855A.

If the supplier is enrolling as a hospital department (under the "Clinic/Group Practice" category on the 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), it is not necessary for the contractor to wait until the provider agreement is issued before conveying billing privileges to the group.

B. Individual Billings

Assume an individual physician works for a hospital and will be billing 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. In this case, the hospital needs to enroll with the contractor via the CMS-855B (e.g., as a hospital department, outpatient location).

15.14.6 – Participation (Par) Agreements and the Acceptance of Assignment

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

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

15.14.7 – Opt-Out

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

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

affidavit to Medicare expressing his/her decision to opt-out of the program. The provider enrollment unit must process these affidavits.

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

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

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

15.14.8 – Reserved for Future Use

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

15.14.9 – Assignment of Part B Provider Transaction Access Numbers (PTANs)

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

The contractor shall only assign the minimum number of PTANs necessary to ensure that proper payments are made. The contractor shall not assign an additional PTAN(s) to a physician, non-physician practitioner, or other supplier merely because the individual or entity requests one, the only exception being for hospitals that request separate billing numbers for their hospital departments in section 2C of the CMS-855B enrollment application. However, a hospital requesting an additional PTAN must associate the new PTAN with an NPI in section 4 of the CMS-855.

15.14.10 – Reciprocal Billing, Locum Tenens and the Provider Enrollment Process

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

15.15 – Internet-based PECOS Applications

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

This section furnishes guidance to contractors on the proper handling and processing of CMS-855 applications submitted via the Internet (hereinafter referred to as "Internet-based PECOS" applications). Unless otherwise stated, the instructions in this section 15.15 apply only to Internet-based PECOS applications.

Contractors shall begin processing such applications as soon as the Internet-based capability is effective for their respective A/M MAC jurisdiction or State/processing area.

A. General Background Information

The principal logging and tracking (L & T) statuses for PECOS Internet applications that are not in a final status are:

- *Received;*
- *In Review;*
- *Returned for Corrections;*
- *Corrections Received;*
- *Review Complete; and*
- *Application in Process.*

The submission of a PECOS Internet application will immediately place the L & T record into a "Received" status.

B. Certification Statement

If the provider fails to submit a signed and dated certification statement to the contractor within 15 calendar days of the date on which it submitted its Internet-based PECOS application to the contractor, the contractor may – but is not required to - reject the application. (For purposes of this policy, the certification statement must be received by the contractor's provider enrollment unit by the 15th day.) The 15-day rule applies to all CMS-855 PECOS Internet applications, regardless of the transaction involved.

For initial PECOS Internet applications (as the term "initial" is defined in section 15.6.1 of this chapter), it is only necessary that the dated signature of at least one of the provider's authorized officials be on the certification statement that must be sent in by the 15th day; obtaining the signatures of the other authorized and delegated officials shall be done through the normal application development process. For PECOS Internet changes of information (as the term "changes of information" is defined in section 15.6.2 of this chapter), if the certification statement is signed by an individual who is not on file with the contractor as being an authorized or delegated official of the provider, the contractor may accept the certification statement but shall develop for information on the person in question in accordance with sections 15.5.15 and 15.5.16 of this chapter.

If the provider submits: (1) an undated certification statement, or (2) a certification statement on which the Web Tracking ID does not match that in PECOS, the contractor shall treat it as a non-submission; while it is recommended that the contractor contact the provider to request a signed/correct certification statement, it is not required. (This requirement applies to any CMS-855 transaction, including requests for additional/clarifying information.)

If the contractor elects to contact the provider to request a dated/valid certification statement, the contractor may give the provider an additional 15 days (or, for that matter, any additional time beyond the initial 15-day period) to submit the new

certification statement. In determining whether to accept an untimely certification statement, the contractor shall take into account factors such as: (1) the degree of the provider's cooperation, (2) the time it took for the certification statement to be transferred from the contractor's main mailroom to the provider enrollment department, and (3) the number of days by which the provider missed the 15-day deadline.

C. Pre-Screening

The contractor shall prescreen all PECOS Internet applications, as the term "prescreen" is defined in section 15.7.1.1 of this chapter.

If the contractor can determine (without actively processing the application) that an application can be returned under section 15.8.1 of this chapter (e.g., was submitted more than 30 days prior to the effective date), the contractor shall return the application without waiting for the arrival of the certification statement.

D. Switch to "In Review" Status

After – and only after - it receives and accepts the provider's certification statement, the contractor shall: (1) enter the date of signature into the "Certification Date" box in the L & T record, and (2) change the L & T status to "In Review." The contractor, in other words, shall not initiate any application verification activities prior to its receipt and acceptance of the certification statement and its completion of tasks (1) and (2) in the previous sentence.

After changing the L & T status to "In Review," the contractor shall review the Application Data Report (ADR), and shall commence all applicable validation activities identified in this chapter. Note that the ADR is only available for printing when the L & T record is in one of the following statuses: "In Review," "Returned for Corrections," or "Corrections Received."

E. Request for Additional/Clarifying Information

If, when performing verification activities, the contractor determines that additional or clarifying information is needed, the contractor shall – after switching the L & T status to "Returned for Corrections" - send an e-mail (via PECOS Internet) to the provider:

- *Requesting said data along with, as necessary, a signed and dated certification statement; and*

- *Listing a date(s) by which the information and certification statement, respectively, must be submitted to the contractor. (The establishment of this submission due date shall be done in accordance with section 5.3(A)(2) of this chapter.)*

(In accordance with sections 15.7.1 through 15.7.2.1 of chapter 15 – and to avoid multiple contacts with the provider - the contractor shall attempt to validate <u>all</u> of the

data on the ADR prior to requesting additional/clarifying information from the provider.)

The contractor shall not attempt to contact the provider for additional/clarifying information prior to sending the e-mail referenced above, though the contractor is free to make a follow-up contact with the provider after sending the e-mail. Note that this e-mail is the only contact that the contractor is required to make per section 5.3 of this chapter.

The provider must submit all applicable supporting documentation (e.g., licenses, CMS-588) with its PECOS Internet application. It is not necessary, however, for the provider to submit the supporting documentation: (1) in the same package as the certification statement, or (2) prior to its submission of the certification statement. Regardless, if the provider fails to submit all applicable supporting documentation, the contractor shall develop for it.

F. Submission of Additional/Clarifying Information

The contractor shall note that a provider may submit requested additional/clarifying data via PECOS Internet or any other mechanism permitted under chapter 15 (e.g., paper, fax).

If the provider fails to submit the requested additional/clarifying information and the accompanying certification statement within 30 calendar days from the date the contractor sent the e-mail referred to above, the contractor shall follow the procedures in sections 15.8.2 (or 15.8.4, as applicable) of this chapter. If, however, the contractor receives the additional/clarifying information from the provider, the contractor shall not recommence its processing of the application until the accompanying certification statement is received in the contractor's provider enrollment department. Once the contractor accepts the newly signed and dated certification statement, it shall enter the certification statement date into the L & T record.

If, after receiving the additional/clarifying information and certification statement from the provider, the contractor determines that further information is needed and elects to request this data from the provider (i.e., elects to waive the "one contact" threshold described in sections 15.7.1 through 15.7.2.1 of this chapter), the contractor shall do so in accordance with the instructions in this chapter.

G. Transferral of Data into PECOS

Once the contractor ties the L & T record to the enrollment record, the contractor shall begin the process of transferring the data into PECOS by accepting or rejecting the various data elements. The contractor shall note that: (1) it cannot undo any transfer of information into PECOS, and (2) once the L & T is tied to the enrollment record, the application cannot be returned to the provider for corrections.

H. Miscellaneous Instructions

The contractor shall note the following:

- ***Deletion of Erroneous Record*** *- The contractor shall only delete an erroneously created L & T record by: (1) moving the L & T record to a status of "Rejected," and (2) using an L & T status reason of "Deleted."*

- ***Gatekeeper/Enrollment Screens*** *- The Gatekeeper and Enrollment screens are only used in the case of CMS-855 initial enrollment PECOS Internet submissions.*

- ***Post-Processing Recordkeeping*** *- After processing a particular PECOS Internet transaction, the contractor shall maintain in the provider's file: (1) a copy of the final version of the ADR, (2) all submitted certification statements and applicable supporting documents, and (3) documentation of all contacts with the provider (e.g., phone calls, e-mails) per section 15.7.3 of this chapter.*

- ***State Agencies*** *- In situations described in this chapter in which the contractor is required to submit a copy of the provider's paper CMS-855 to the State agency, the contractor shall send a copy of the ADR in lieu of the CMS-855 if the provider sent in its application via the Internet.*

15.21 – Special Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Instructions

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

This section instructs the NSC on the appropriate handling of certain situations involving DMEPOS suppliers.

15.21.1 – DMEPOS Supplier Accreditation

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

The DMEPOS suppliers must be accredited prior to submitting an application to NSC on or after March 1, 2008. The NSC shall not approve any DMEPOS supplier's enrollment application if the enrollment package does not contain an approved accreditation upon receipt or in response to a developmental request. The NSC may reject an enrollment application if the DMEPOS supplier fails to provide supporting documentation which demonstrates that the supplier has an approved accreditation. Moreover, for any application that is pending (i.e., not processed to completion) as of March 1, 2008, the contractor shall develop for accreditation.

The DMEPOS suppliers that are enrolled for the first time with the NSC between January 1, 2008, and February 28, 2008, must obtain and submit an approved accreditation to the NSC by January 1, 2009. The NSC shall revoke a DMEPOS supplier's billing privileges if the DMEPOS supplier fails to obtain and submit supporting documentation that the DMEPOS supplier has been accredited.

The DMEPOS suppliers enrolled in the Medicare program prior to January 1, 2008, are required to obtain and submit an approved accreditation to the NSC by September 30, 2009. The NSC shall revoke a DMEPOS supplier's billing privileges if the DMEPOS supplier fails to obtain and submit supporting documentation that the DMEPOS supplier has been accredited.

15.21.2 – Enrolling Indian Health Service (IHS) Facilities as DMEPOS Suppliers

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

The NSC shall enroll IHS facilities as DMEPOS suppliers in accordance with the general enrollment procedures cited in chapter 15 and the statement of work contained in the NSC contract with Medicare, with the addition of the special procedures and clarifications cited in this section.

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

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

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

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

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

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

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

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

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

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

3. Provider Education for IHS Facilities

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

4. Specialty Codes

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

15.21.3 - Special Situations Concerning Accreditation and Enrollment

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

1. A change of ownership application for an existing supplier location submitted by a new owner company with a new tax identification number (TIN) shall be rejected (consistent with 42CFR §424.525) if the new owner does not have an accreditation that covers all of its locations. If the old owner does have such an accreditation, the new owner could be enrolled as of the date of sale if the accreditor determines that the accreditation should remain in effect as of the date of sale. (This, however, is only applicable when the new owner also meets all other enrollment criteria found at 42CFR §424.57). If the new owner submits an application without evidence that the accreditation is still in effect for the new owner, the application should be rejected.

2. Some ownership changes do not result in a complete change of ownership, since the business entity remains the same with no change in TIN. However, in cases where more than 5 percent of the ownership has changed, the following principles apply:

- *If the change in ownership has not been reported to the NSC within the required 30-day period, the NSC shall proceed with revocation action.*

- *If the change has been received within the required 30-day period and the supplier has been accredited, the NSC shall immediately notify the accreditor of the ownership change and request that the latter advise the NSC if the accreditation should still remain in effect.*

3. A DMEPOS supplier requesting reactivation after a deactivation for non-billing shall be required to be accredited on or after March 1, 2008.

4. A revoked DMEPOS supplier that has submitted an acceptable corrective action plan can be reinstated without accreditation unless the accreditation was already required prior to revocation.

5. A DMEPOS supplier that has been deactivated for failing to respond to a reenrollment request shall obtain accreditation if the reenrollment occurs after February 29, 2008.

6. DMEPOS suppliers with 25 or more enrolled locations prior to March 1, 2008, may enroll additional locations without accreditation until September 30, 2009.

15.21.4 - Development and Use of Fraud Level Indicators

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

The NSC-MAC shall perform a fraud potential analysis of all DMEPOS applicants and current DMEPOS suppliers. The fraud level indicator shall represent the potential for fraud and/or abuse. The NSC-MAC shall use four fraud level indicator codes as follows:

1. *Low Risk (e.g., national drug store chains),*

2. *Limited Risk (e.g., prosthetist in a low fraud area),*

3. *Medium Risk (e.g., midsize general medical supplier in a high fraud area), and*

4. *High Risk (e.g., very small space diabetic supplier with low inventory in a high fraud area whose owner has previously had a chapter 7 bankruptcy). High fraud areas shall be determined by contractor analysis with concurrence of the NSC-MAC's project officer.*

In assessing a fraud level indicator, the NSC-MAC shall consider such factors as:

1. *Experience as a DMEPOS supplier with other payers,*
2. *Prior Medicare experience,*
3. *The geographic area,*
4. *Fraud potential of products and services listed,*
5. *Site visit results,*
6. *Inventory observed and contracted, and*
7. *Accreditation of the supplier.*

After a fraud level indicator is assigned and the DMEPOS supplier is enrolled, the NSC-MAC shall establish a DMEPOS Review Plan based on the fraud level assessment. The DMEPOS Review Plan would contain information regarding:

1. *Frequency of unscheduled site visits,*
2. *Maximum billing amounts before recommendation for prepay medical review,*
3. *Maximum billing spike amounts before recommendation for payment suspensions/prepay medical review, etc.*

The fraud level indicator shall be updated based upon information obtained through the Medicare enrollment process, such as reported changes of information.

Information obtained by the Office of Inspector General (OIG), CMS (including CMS satellite office) and/or a PSC shall be reported to the NSC-MAC project officer or its designee. The NSC-MAC shall update the fraud level indicator based on information obtained by the OIG, CMS (including CMS satellite office) and/or a PSC only after the review and concurrence of the NSC-MAC project officer or its designee.

In addition, the NSC-MAC should monitor and assess geographic trends which indicate or demonstrate that one geographic area has a higher potential for having fraudulent suppliers.

15.21.4.1 - Fraud Prevention and Detection

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

The NSC-MAC shall have documented evidence that they have, as a minimum, met the requirements shown below:

- *Assign an appropriate fraud level indicator for at least 95 percent of all DMEPOS suppliers, upon initial or reenrollment. The fraud level indicator shall accurately reflect the risk the supplier poses to the Medicare program based on pre-defined criteria above.*

- *Update the DMEPOS fraud level indicator for each enrolled DMEPOS supplier on an annual basis.*

15.21.5 - Alert Codes

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

The NSC-MAC shall receive and maintain the following "alert indicators" from the DME-MACs and payment safeguard contractors (PSCs)/zone program integrity contractors (ZPICs):

Alert Code	*Definition*
A	*possible fraudulent or abusive claims identified;*
B	*overpayments;*
D	*violations of disclosure of ownership requirements;*
E	*violations of participation agreements;*
L	*suspended by Contractor outside alert code process; and*
M	*supplier is going through claims appeal process.*

The NSC-MAC shall append the supplier file and transfer to the DME-MACs and PSCs/ZPICs the following alert codes in the following circumstances:

Alert Code	*Definition*
C	*Violations of supplier standards;*
F	*Sanctioned by the Office of Inspector General or excluded by the GSA;*
H	*Meets supplier standards; however, the NSC-MAC recommends increased scrutiny by the contractor (initiated by NSC-MAC only);*
N	*Supplier being investigated under the "Do Not Forward" initiative (initiated by NSC-MAC only);*
Q	*Low Risk Fraud Level Indicator;*
R	*Limited Risk Fraud Level Indicator;*
S	*Medium Risk Fraud Level Indicator; and*
T	*High Risk Fraud Level Indicator.*

The NSC-MAC shall append an Alert Code "H" for any supplier that meets present supplier standards but appears suspect in one of the areas that are verified by the NSC-MAC. This alert code notifies the contractors that a supplier may be inclined to submit a high percentage of questionable claims.

The NSC-MAC shall share the above information with the DME-MACs and PSCs/ZPICs by sending alerts within 7 calendar days after identification of a supplier having common ownership or business ties with a sanctioned or suspect supplier for their research and/or action. The NSC-MAC also shall forward alert codes submitted by the contractors with the other contractors within 7 calendar days after receipt.

15.21.6 - Accreditation

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

The NSC-MAC shall follow the accreditation requirements in the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA).

Individual medical practitioners, inclusive of group practices of same, shall not currently require accreditation for enrollment. The practitioner types are those specifically stated in Sections 1848(K)(3)(B) and 1842(b)(18)(C) of the Social Security Act as Amended. In addition, the practitioner categories of physicians, orthotists, prosthetists, optometrists, opticians, audiologists, occupational therapists, physical therapists and suppliers who provide drugs and pharmaceuticals (only) shall not currently require accreditation for enrollment.

Suppliers that provide only drugs and pharmaceuticals are exempt from the accreditation requirement; however, if the supplier provides equipment to administer drugs or pharmaceuticals, the supplier must be accredited.

If a previously exempted supplier enrollment application was returned for non-accreditation, the supplier must resubmit its CMS-855S Medicare enrollment application to the NSC to obtain/maintain Medicare billing privileges.

15.21.7 – Surety Bonds

(Rev. 405, Issued: 01-26-12, Effective 02-27-12, Implementation: 02-27-12)

A. Background

1. Surety Bond Exemptions

All DMEPOS suppliers are subject to the surety bond requirement, except:

- *Government-operated DMEPOS suppliers are exempted if the supplier has provided CMS with a comparable surety bond under State law.*

- *State-licensed orthotic and prosthetic personnel (which, for purposes of the surety bond requirement, does <u>not</u> include pedorthists) in private practice making custom-made orthotics and prosthetics are exempted if—*

    - *The business is solely-owned and operated by the orthotic and prosthetic personnel, and*

- *The business is only billing for orthotic, prosthetics, and supplies.*

- *Physicians and non-physician practitioners, as defined in section 1842(b)(18) of the Social Security Act, are exempted if the items are furnished only to the physician or non-physician practitioner's own patients as part of his or her physician service. The non-physicians covered under this exception are: physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse-midwives, clinical social workers, clinical psychologists, and registered dietitians or nutrition professionals.*

- *Physical and occupational therapists in private practice are exempted if—*

  - *The business is solely-owned and operated by the physical or occupational therapist;*

  - *The items are furnished only to the physical or occupational therapist's own patients as part of his or her professional service; and*

  - *The business is only billing for orthotics, prosthetics, and supplies.*

If a previously-exempted DMEPOS supplier no longer qualifies for an exception, it must submit a surety bond to the NSC - in accordance with the requirements in 42 CFR §424.57 - within 60 days after it knows or has reason to know that it no longer meets the criteria for an exception.

2. Bond Submission

*Effective May 4, 2009, DMEPOS suppliers submitting: (1) an initial enrollment application to enroll in the Medicare program for the first time, (2) an initial application to establish a new practice location, or (3) an enrollment application to change the ownership of an existing supplier, are required to obtain and submit a copy of its required surety bond to the NSC with their CMS-855S enrollment application. (**NOTE:** Ownership changes that do not involve a change in the status of the legal entity as evidenced by no change in the tax identification number, or changes that result in the same ownership at the level of individuals (corporate reorganizations and individuals incorporating) are not considered to be "changes of ownership" for purposes of the May 4, 2009, effective date – meaning that such suppliers are considered "existing" suppliers).*

For any CMS-855S application submitted on or after May 4, 2009, by a supplier described in this section (2), the NSC shall reject the application if the supplier does not furnish a valid surety bond at the time it submits its application. The rejection shall be done in accordance with existing procedures (e.g., reject application after 30 days).

3. Amount and Basis

The surety bond must be in an amount of not less than $50,000 and is predicated on the NPI, not the tax identification number. Thus, if a supplier has two separately-enrolled DMEPOS locations, each with its own NPI, a $50,000 bond must be obtained for each site.

A supplier may obtain a single bond that encompasses multiple NPIs/locations. For instance, if a supplier has 10 separately-enrolled DMEPOS locations, it may obtain a $500,000 bond that covers all 10 locations.

As stated in 42 CFR §424.57(d)(3), a supplier will be required to maintain an elevated surety bond amount of $50,000 for each final adverse action imposed against it within the 10 years preceding enrollment or reenrollment. This amount is in addition to, and not in lieu of, the base $50,000 amount that must be maintained. Thus, if a supplier has had two adverse actions imposed against it, the bond amount will be $150,000.

A final adverse action is one of the following:

- *A Medicare-imposed revocation of Medicare billing privileges;*
- *Suspension or revocation of a license to provide health care by any State licensing authority;*
- *Revocation or suspension by an accreditation organization;*
- *A conviction of a Federal or State felony offense (as defined in §424.535(a)(3)(i)) within the last 10 years preceding enrollment or re-enrollment; or*
- *An exclusion or debarment from participation in a Federal or State health care program.*

4. Bond Terms

The supplier is required to submit a copy of the bond that - on its face - reflects the requirements of 42 CFR §424.57(d). Specific terms that the bond must contain include:

- *A guarantee that the surety will - within 30 days of receiving written notice from CMS containing sufficient evidence to establish the surety's liability under the bond of unpaid claims, civil monetary penalties (CMPs), or assessments - pay CMS a total of up to the full penal amount of the bond in the following amounts:*
- *The amount of any unpaid claim, plus accrued interest, for which the DMEPOS supplier is responsible, and*
- *The amount of any unpaid claims, CMPs, or assessments imposed by CMS or the OIG on the DMEPOS supplier, plus accrued interest.*

- *A statement that the surety is liable for unpaid claims, CMPs, or assessments that occur during the term of the bond.*

- *A statement that actions under the bond may be brought by CMS or by CMS contractors.*

- *The surety's name, street address or post office box number, city, State, and zip code.*

- *Identification of the DMEPOS supplier as the Principal, CMS as the Obligee, and the surety (and its heirs, executors, administrators, successors and assignees, jointly and severally) as the surety.*

The term of the initial surety bond must be effective on the date that the application is submitted to the NSC. Moreover, the bond must be continuous.

5. Sureties

The list of sureties from which a bond can be secured is found at Department of the Treasury's "Listing of Certified (Surety Bond) Companies;" the Web site is ***www.fms.treas.gov/c570/c570_a-z.html****. For purposes of the surety bond requirement, these sureties are considered "authorized" sureties, and are therefore the only sureties from which the supplier may obtain a bond.*

6. Bond Cancellations and Gaps in Coverage

A DMEPOS supplier may cancel its surety bond, but must provide written notice of such to the NSC and the surety at least 30 days before the effective date of the cancellation. Cancellation of a surety bond is grounds for revocation of the supplier's Medicare billing privileges unless the supplier provides a new bond before the effective date of the cancellation. The liability of the surety continues through the termination effective date.

If a gap in coverage exists, the NSC shall revoke the supplier's billing privileges. If a supplier changes its surety during the term of the bond, the new surety is responsible for any overpayments, CMPs, or assessments incurred by the DMEPOS supplier beginning with the effective date of the new surety bond; the previous surety is responsible for any overpayments, CMPs, or assessments that occurred up to the date of the change of surety.

Pursuant to 42 CFR 424.57(d)(6)(iv), the surety must notify the NSC if there is a lapse in the surety's coverage of the DMEPOS supplier. This can be done via letter, fax, or e-mail to the NSC; the appropriate addresses can be found on the NSC's Web site at www.palmettogba.com/nsc.

7. Reenrollment and Reactivation

The supplier must furnish the paperwork described in subsection (A)(4) above with any CMS-855S reenrollment or reactivation application it submits to the NSC unless it already has the information on file with the NSC. For example, if a supplier has submitted a continuous surety bond to the NSC prior to submission of its reenrollment application, a new copy of surety bond is not be required unless the NSC specifically requests it.

B. Bond Changes

A DMEPOS supplier must submit an addendum to the existing bond (or, if the supplier prefers, a new bond) to the NSC in the following instances: (1) change in bond terms, (2) change in bond amount, or (3) a location on a bond covering multiple non-chain locations is being added or deleted.

15.21.9 – Compliance Standards for Enrollment of Mail Order Pharmacies and Suppliers of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Delivered Through Other Than the Supplier's Location or Beneficiary Address