CMS Manual System

Pub 100-08 Medicare Program Integrity

Transmittal 146

Department of Health & Human Services (DHHS)

Centers for Medicare & Medicaid Services (CMS)

Date: APRIL 28, 2006

Change Request 4340

SUBJECT: Provider Enrollment Update

I. SUMMARY OF CHANGES: The chapter on provider enrollment requires updating. The introduction and definitions have been revised. Several definitions have been deleted along with section 1.3. Section 1.2 will now be defined as contractor duties

NEW/REVISED MATERIAL
EFFECTIVE DATE: May 30, 2006
IMPLEMENTATION DATE: May 30, 2006

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS:
R = REVISED, N = NEW, D = DELETED

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	10/Table of Contents
R	10/1/Introduction
R	10/1.1/Definitions
R	10/1.2/Contractor Duties
D	10/1.3/Benefit Integrity (BI)/Payment Safeguard Versus Provider Enrollment

III. FUNDING:

No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.

IV. ATTACHMENTS:

Attachment - Business Requirements

Pub. 100-08	Transmittal: 146	Date: April 28, 2006	Change Request 4340

SUBJECT: Provider Enrollment Update

I. GENERAL INFORMATION

A. Background: The chapter on provider enrollment requires updating. The introduction and definitions have been revised. Several definitions have been deleted along with section 1.3. Section 1.2 will now be defined as contractor duties.

B. Policy:

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4340.1	Contractors shall refer to Pub. 100-08, chapter 10, section 1.1 for definitions related to provider enrollment.	X	X	X						NSC
4340.2	Contractors shall prescreen each provider enrollment application to ensure that it is complete and that all information and documentation has been submitted.	X	X	X						NSC
4340.3	Contractors shall conduct verification, validation and final processing according to the items listed in Pub. 100-08, chapter 10, section 1.2.	X	X	X						NSC
4340.4	The NSC shall maintain a national master file of all durable medical equipment suppliers and share that information with the Durable Medical Equipment Regional Contractors (DMERC).									NSC

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4340.5	Contractors shall establish, update and close provider and supplier records in PECOS.	X	X	X						

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	None.									

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: May 29, 2006 **Implementation Date:** May 29, 2006 per Jeff Hinson **Pre-Implementation Contact(s):** Alisha Banks, 410-786-0671 **Post-Implementation Contact(s):** Alisha Banks, 410-786-0671	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.**

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

Medicare Program Integrity Manual

Chapter 10 - *Medicare Provider and Supplier Enrollment*

Table of Contents
(Rev. 146, 04-28-06)

1 - Introduction

(Rev. 146, Issued: 04-28-06; Effective/Implementation Dates: 05-30-06)

This chapter specifies the resources and procedures Medicare fee-for-service contractors must use to establish and maintain provider and supplier enrollment in the Medicare program. These procedures apply to carriers, fiscal intermediaries, Medicare administrative contractors and the National Supplier Clearinghouse, unless contract specifications state otherwise.

No provider or supplier shall receive payment for services furnished to a Medicare beneficiary unless the provider or supplier is enrolled in the Medicare program. Further, it is essential that each provider and supplier enroll with the appropriate Medicare fee-for-service contractor.

1.1 – Definitions

(Rev. 146, Issued: 04-28-06; Effective/Implementation Dates: 05-30-06)

Below is a list of terms commonly used in the Medicare enrollment process.

Applicant *means an* individual (practitioner/supplier) or *an* organization *that* is *seeking enrollment into the Medicare program.*

Approve/Approval means the enrolling provider or supplier has been determined to be eligible under Medicare rules and regulations to receive a Medicare billing number and *will* be granted Medicare billing privileges.

Authorized Official *means* an appointed official *(e.g., chief executive officer, chief financial officer, general partner, chairman of the board, or direct owner)* to whom the *organization* has granted the legal authority to enroll it in the Medicare program, to make changes or updates to the *organization's* status in the Medicare program, and to commit the *organization* to fully abide by the *statutes*, regulations, and program instructions of *the* Medicare *program.*

Billing Agency *means* a company that the applicant contracts with to prepare, *edit and/or submit claims on applicant's behalf.*

Change of Ownership (CHOW) is defined in 42 CFR 489.18 (a) and generally means, in the case of a partnership, the removal, addition, or substitution of a partner, unless the partners expressly agree otherwise, as permitted by applicable State law. In the case of a corporation, the term generally means the merger of the provider corporation into another corporation, resulting in the creation of a new corporation. The transfer of corporate stock or the merger of another corporation into the provider corporation does not constitute change of ownership.

Deactivated means that the provider or supplier's billing privileges were stopped, but can be restored upon the submission of updated information.

Delegated Official means an individual who is delegated, by the *"Authorized Official," the authority to report changes and updates to the enrollment record. The delegated official must be an individual with ownership or control interest in, or be a W-2 managing employee of the provider or supplier.*

Deny/Denial means the enrolling provider or supplier has been denied enrollment into the Medicare program because the provider has been determined to be ineligible to receive Medicare billing privileges for Medicare covered items or services provided to Medicare beneficiaries.

Enroll/Enrollment means the process that Medicare uses to establish eligibility to submit claims for Medicare covered services and supplies. The process includes:

- *Identification of a provider or supplier;*
- *Validation of the provider or supplier's eligibility to provide items or services to Medicare beneficiaries;*
- *Identification and confirmation of the provider or supplier's practice location(s); and,*
- *Granting the provider or supplier Medicare billing privileges.*

Enrollment Application means a CMS-approved paper enrollment application or an electronic Medicare enrollment process approved by the Office of Management and Budget (OMB).

Legal Business Name *is* the name that is reported to the Internal Revenue Service.

Managing Employee means a general manager, business manager, administrator, director, or other individual that exercises operational or managerial control over, or who directly or indirectly conducts, the day-to-day operation of the provider or supplier, either under contract or through some other arrangement, whether or not the individual is a W-2 employee of the provider or supplier.

Medicare Identification Number is the generic term for any number, other than the National Provider Identifier, used by a provider or supplier to bill the Medicare program.

National Provider Identifier is the standard unique health identifier for health care providers (including Medicare suppliers) and is assigned by the National Plan and Provider Enumeration System.

Operational means the provider or supplier has a qualified physical practice location; is open to the public for the purpose of providing healthcare related services; is prepared to submit valid Medicare claims; and, is properly staffed, equipped, and stocked (as

applicable, based on the type of facility or organization, provider or supplier specialty, or the services or items being rendered) to furnish these items or services.

Owner means any individual or entity that has any partnership interest in, or that has 5 percent or more direct or indirect ownership of the provider or supplier as defined in sections 1124 and 1124(A) of the Act.

Provider is defined at 42 CFR 400.202 and generally means a hospital, critical access hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility (CORF), home health agency or hospice, that has in effect an agreement to participate in Medicare; or a clinic, rehabilitation agency, or public health agency that has in effect a similar agreement but only to furnish outpatient physical therapy or speech pathology services; or a community mental health center that has in effect a similar agreement but only to furnish partial hospitalization services.

Reactivation means that a provider/supplier's billing privileges have been restored.

Reassignment means that *a physician or other individual supplier has give permission to bill and receive payment for services furnished to a Medicare beneficiary.*

Reject/Rejected (also referred to as Return/Returned) means that the provider or supplier's enrollment application was not processed due to incomplete information or that additional information or corrected information was not received from the provider or supplier in a timely manner.

Revoke/Revocation means that the provider or supplier's billing privileges are terminated.

Supplier is defined in 42 CFR 400.202 and means a physician or other practitioner, or an entity other than a provider that furnishes health care services under Medicare.

Tax Identification Number *means* the *number (either the Social Security Number (SSN) or Employer Identification Number (EIN))* the individual or organization uses to report tax information to the IRS.

Voluntary Termination means that a provider or supplier is withdrawing from the Medicare program.

1.2 – Contractor Duties
(Rev. 146, Issued: 04-28-06; Effective/Implementation Dates: 05-30-06)

Medicare fee-for-service contractors must adhere to the processing guidelines established in chapter 10, of the Program Integrity Manual. In addition, fee-for-service contractors shall assign the appropriate number of staff to the Medicare enrollment function to meet established processing time frames.

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

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

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

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

Conduct Prescreening

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

Conduct Verification, Validation, and Final Processing

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

- *Coordinate with state survey/certification agencies and regional offices, as needed.*

- *Collect and maintain the application's certification statement (in house) to verify and validate changes to a pay-to address. The change request signature must be checked against the original signature to determine the validity of any change to a pay-to address. This check can be made against a digital/photo image kept in-house.*

- *Confirm that the applicant, all names and entities listed on the application, and any names or entities ascertained through the use of an independent verification source, are not presently excluded from the Medicare program by the HHS Office of Inspector General (OIG). Contractors shall confirm and submit data through*

Qualifier.net, the Medicare Exclusion Database (MED), General Services Administration and the Fraud Investigation Database in accordance with existing CMS instructions and directives.

- *Confirm that enrolled providers and suppliers are reviewed periodically against the MED. This is to ensure that billing privileges are not retained by providers/suppliers that become excluded after enrollment.*

- *Review and investigate billing agency agreements and provider/supplier reassignments of Medicare payments to ensure full compliance with operational guidelines at the time of initial review and periodically, if necessary.*

Coordinate with other Contractors

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

Use of and Establish Records in PECOS

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

Business Requirements
Manual Instruction

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