| CMS Manual System | Department of Health & Human Services (DHHS) |
|---|---|
| Pub 100-08 Medicare Program Integrity | Centers for Medicare & Medicaid Services (CMS) |
| Transmittal 150 | Date: JUNE 30, 2006 |
| | Change Request 5139 |

**Subject: Re-issuance of Chapter 10, Introduction of Provider Enrollment**

**I. SUMMARY OF CHANGES:** There are several reasons for this re-issuance. CMS has revised its provider enrollment applications (CMS-855) and issued a new provider enrollment regulation (6002-P). The re-issued chapter 10 furnishes instructions relating to these documents. It also incorporates provider enrollment policies that have been developed since 2003. Much of the current language in chapter 10 has been re-written so as to make it clearer and more concise. Finally, duplicative data in various sections of the chapter has been eliminated.

**NEW / REVISED MATERIAL**
**EFFECTIVE DATE: JULY 3, 2006**
**IMPLEMENTATION DATE: JULY 3, 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 to Provider Enrollment |
| **R** | 10/1.1/Definitions |
| **R** | 10/1.2/CMS-855 Medicare Enrollment Applications |
| **R** | 10/1.3/Medicare Contractor Duties |
| **R** | 10/2/Timeliness Standards |
| **R** | 10/2.1/Timeframes for Initial Applications |
| **R** | 10/2.2/Timeframes for Changes of Information |
| **R** | 10/2.3/General Timeliness Principles |
| **D** | 10/2.4/Acknowledgment of Receipt |
| **R** | 10/3/Pre-Screening and Application Returns |
| **R** | 10/3.1/Pre-Screening Process |

| | |
|---|---|
| **R** | 10/3.2/Returning the Application |
| **D** | 10/3.3/Adverse Legal Actions and Overpayments |
| **D** | 10/3.4/Practice Location |
| **D** | 10/3.5/Ownership and Managing Control Information (Organizations) |
| **D** | 10/3.6/Ownership and Managing Control Information (Individuals) |
| **D** | 10/3.7/Chain Home Office Information |
| **D** | 10/3.8/Billing Agency |
| **D** | 10/3.9/Electronic Claims Submission Information |
| **D** | 10/3.10/Staffing Company |
| **D** | 10/3.11/Surety Bond Information |
| **D** | 10/3.12/Capitalization Requirement for Home Health Agencies |
| **D** | 10/3.13/Contact Person |
| **D** | 10/3.14/Penalties for Falsifying Information on This Application |
| **D** | 10/3.15/Certification Statement |
| **D** | 10/3.16/Delegated Official |
| **D** | 10/3.17/Attachments |
| **R** | 10/4/Application Review |
| **R** | 10/4.1/Basic Information (Section 1 of the CMS-855) |
| **R** | 10/4.2/Identifying Information (Section 2 of the CMS-855) |
| **N** | 10/4.2.1/Tax Identification Numbers and Legal Business Names |
| **N** | 10/4.2.2/Licenses and Certifications |
| **N** | 10/4.2.3/Correspondence Address |
| **N** | 10/4.2.4/Accreditation |
| **N** | 10/4.2.5/Section 2 of the CMS-855A |
| **N** | 10/4.2.6/Section 2 of the CMS-855B |
| **N** | 10/4.2.7/Section 2 of the CMS-855I |
| **R** | 10/4.3/Adverse Legal Actions/Convictions |
| **R** | 10/4.4/Practice Location Information |
| **N** | 10/4.4.1/Section 4 of the CMS-855A |
| **N** | 10/4.4.2/Section 4 of the CMS-855B |
| **N** | 10/4.4.3/Section 4 of the CMS-855I |

| | |
|---|---|
| **R** | 10/4.5/Owning and Managing Organizations |
| **R** | 10/4.6/Owning and Managing Individuals |
| **N** | 10/4.7/Chain Organizations |
| **N** | 10/4.8/Billing Agencies |
| **N** | 10/4.9/Reserved for Future Use |
| **N** | 10/4.10/Reserved for Future Use |
| **N** | 10/4.11/Reserved for Future Use |
| **N** | 10/4.12/Special Requirements for Home Health Agencies (HHAs) |
| **N** | 10/4.13/Contact Person |
| **N** | 10/4.14/Reserved for Future Use |
| **N** | 10/4.15/Certification Statement |
| **N** | 10/4.16/Delegated Official |
| **N** | 10/4.17/Reserved for Future Use |
| **N** | 10/4.18/Ambulance Attachment |
| **N** | 10/4.19/IDTF Attachment |
| **N** | 10/4.19.1/IDTF Standards |
| **N** | 10/4.19.2/CPT-4 and HCPCS Codes |
| **N** | 10/4.19.3/Interpreting Physicians |
| **N** | 10/4.19.4/Technicians |
| **N** | 10/4.19.5/Supervising Physicians |
| **N** | 10/4.19.6/Desk and Site Reviews |
| **N** | 10/4.19.7/Special Procedures and Supplier Types |
| **N** | 10/4.19.8/Billing Issues |
| **N** | 10/4.20/Processing CMS-855R Applications |
| **N** | 10/4.21/National Provider Identifier (NPI) |
| **R** | 10/5/Verification and Validation |
| **R** | 10/5.1/General Verification Principles |
| **R** | 10/5.2/Verification of Data |
| **R** | 10/5.3/Requesting and Receiving Clarifying Information |
| **R** | 10/5.4/Special Verification Procedures for CMS-855B, CMS-855I and CMS-855R Applications |
| **N** | 10/5.5/Special Verification Procedures for CMS-855A Applications |

| | |
|---|---|
| **N** | 10/5.6/Special Verification Procedures for Enrolling Independent CLIA Labs, Ambulatory Surgical Centers (ASCs), and Portable X-ray Suppliers |
| **N** | 10/5.7/Special Procedures for Processing Full CMS-855 Applications Submitted by Enrolled Providers |
| **R** | 10/6/Final Application Actions |
| **N** | 10/6.1/Approvals |
| **N** | 10/6.1.1/Non-Certified Suppliers and Individuals Practitioners |
| **N** | 10/6.1.2/Certified Providers and Certified Suppliers |
| **N** | 10/6.2/Denials |
| **R** | 10/7/Changes of Information |
| **R** | 10/7.1/General Procedures |
| **R** | 10/7.2/Special Instructions for Certified Providers, ASCs, and Portable X-ray Suppliers |
| **R** | 10/7.3/Voluntary Terminations |
| **D** | 10/7.4/Practice Location |
| **D** | 10/7.5/Statement of Termination |
| **D** | 10/7.6/Reassignment of Benefits Statement |
| **D** | 10/7.7/Attestation Statement |
| **R** | 10/8/Electronic Fund Transfers (EFT) |
| **R** | 10/9/Revalidation |
| **R** | 10/10/Documentation |
| **D** | 10/10.1/Processing the Application |
| **D** | 10/10.2/Provider Identification |
| **D** | 10/10.3/Adverse Legal Actions and Overpayments |
| **D** | 10/10.4/Practice Location |
| **D** | 10/10.5/Ownership and Managing Control Information (Organizations) |
| **D** | 10/10.6/Ownership and Managing Control Information (Individuals) |
| **D** | 10/10.7/Chain Home Office Information |
| **D** | 10/10.8/Billing Agency |
| **D** | 10/10.9/Electronic Claims Submission Information |
| **D** | 10/10.10/Staffing Company |
| **D** | 10/10.11/Surety Bond Information |

| | |
|---|---|
| **D** | 10/10.12/Capitalization Requirements for Home Health Agencies (HHAs) |
| **D** | 10/10.13/Contact Person |
| **D** | 10/10.14/Penalties for Falsifying Information |
| **D** | 10/10.15/Certification Statement |
| **D** | 10/10.16/Delegated Official |
| **D** | 10/10.17/Special Processing Situations |
| **R** | 10/11/Special Processing Situations |
| **R** | 10/11.1/Tie-In Notices |
| **R** | 10/11.2/Out-of-State Practice Locations for Certified Providers |
| **R** | 10/11.3/Provider-Based |
| **N** | 10/11.4/State Survey Actions |
| **N** | 10/11.5/Carrier Processing of Hospital Applications |
| **N** | 10/11.6/Par Agreements |
| **N** | 10/11.7/Opt-Out |
| **R** | 10/12/Provider and Supplier Types/Services |
| **N** | 10/12.1/Community Mental Health Centers (CMHCs) |
| **N** | 10/12.2/Diabetes Self-Management Training (DSMT) |
| **N** | 10/12.3/Mass Immunizers Who Roster Bill |
| **N** | 10/12.4/Enrolling Indian Health Service (IHS) Facilities as Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Suppliers |
| **R** | 10/13/Reserved for Future Use |
| **R** | 10/14/Model Correspondence Language |
| **D** | 10/14.1/Request for Additional Information |
| **D** | 10/14.2/Approval and Recommendations for Approval |
| **D** | 10/14.3/Denials |
| **D** | 10/14.4/Revocations |
| **R** | 10/15/PECOS |
| **R** | 10/16/External Reporting Requirements |
| **D** | 10/16.1/Fraud Investigation Database |
| **D** | 10/16.2/Healthcare Integrity and Protection Data Bank |
| **D** | 10/16.3/Uncovering Fraud and Abuse |
| **D** | 10/16.4/Excluded Parties List System (General Service |

| | |
|---|---|
| | Administration (GSA) Debarment) |
| **R** | 10/17/Maintenance and Release of CMS-855 Data |
| **R** | 10/17.1/Security |
| **R** | 10/17.2/Release of Information |
| **R** | 10/17.3/File Maintenance |
| **D** | 10/17.4/Railroad Retirement Board (RRB) |
| **D** | 10/17.5/Provider-Based Processing and Change of Status |
| **R** | 10/18/Customer Service |
| **N** | 10/18.1/Web Sites |
| **N** | 10/18.2/Provider Enrollment Inquiries |
| **D** | 10/20/Tracking Requirements |
| **D** | 10/21/Retention of Records |
| **D** | 10/22/Provider/Supplier Education |
| **D** | 10/23/Web Site |
| **D** | 10/24/Security Safeguards |
| **D** | 10/25/Documentation |
| **D** | 10/26/File Maintenance and Review |
| **D** | 10/27/Provider Enrollment, Chain and Ownership System (PECOS) |
| **D** | 10/28/Enrolling Indian Health Services (IHS) Facilities as Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Suppliers |

**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:**

**Business Requirements**

**Manual Instruction**

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

# Attachment - Business Requirements

| Pub. 100-08 | Transmittal: 150 | Date: June 30, 2006 | Change Request 5139 |
|---|---|---|---|

**SUBJECT: Re-issuance of Chapter 10, Introduction of Provider Enrollment**

## I. GENERAL INFORMATION

**A. Background:** CMS is re-issuing Pub.100-08, Program Integrity Manual, chapter 10. There are several reasons for the re-issuance. CMS has issued revised provider enrollment applications (CMS-855) and a new provider enrollment regulation (6002-P). The re-issued chapter 10 furnishes instructions relating to these documents. Second, the chapter incorporates provider enrollment policies that have been developed since 2003. Much of the current language in chapter 10 has been re-written so as to make it clearer and more concise. Finally, duplicative data in various sections of the current chapter 10 has been eliminated.

**B. Policy:** DPSE is reissuing chapter 10 to include the aforementioned information and editorial corrections. The requirements below generally correspond to the order of the sections of the reissued manual.

## 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 | |
| 5139.1 | Contractors shall furnish information to providers and suppliers on how to access the CMS-855 enrollment applications, per section 1.2 of Chapter 10. | X | X | X | | | | | | National Supplier Clearinghouse |
| 5139.2 | Contractors shall create an L & T record and, if applicable, an enrollment record in PECOS no later than 15 calendar days of receipt of the provider's application, per section 2.3 of chapter 10. | X | X | X | | | | | | |

| Requirement Number | Requirements | Responsibility ("X" indicates the columns that apply) | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | FI | RHHI | Carrier | DMERC | Shared System Maintainers | | | | Other |
| | | | | | | FISS | MCS | VMS | CWF | |
| 5139.3 | Contractors shall pre-screen CMS-855 applications no later than 15 calendar days after the date of receipt, per section 3.1 of chapter 10. | X | X | X | | | | | | National Supplier Clearinghouse |
| 5139.4 | Contractors shall return CMS-855 applications to providers in the situations described in section 3.2 of chapter 10. | X | X | X | | | | | | National Supplier Clearinghouse |
| 5139.5 | Contractors shall note that sections 3 through 3.17, as well as sections 10 through 10.17, of the current chapter 10 have been consolidated into sections 4 through 4.17 of the reissued chapter 10. | X | X | X | | | | | | National Supplier Clearinghouse |
| 5139.6 | Contractors shall verify social security numbers (SSNs) and employer identification numbers (EINs) in accordance with section 4.2.1 of the reissued chapter 10. | X | X | X | | | | | | National Supplier Clearinghouse |
| 5139.7 | Contractors shall, if applicable, advise providers of the cost reporting information discussed in section 4.2.5 of the reissued chapter 10. | X | X | | | | | | | |
| 5139.8 | Contractors shall, if applicable, advise providers that a recommendation of approval of a home health agency (HHA) branch or hospital unit does not signify CMS's approval of the addition. | X | X | | | | | | | |
| 5139.9 | Contractors shall, if applicable, create a separate enrollment record in PECOS for any practice location that has an Online Survey Certification and Reporting System (OSCAR) number different from that of the main provider. | X | X | | | | | | | |

| Requirement Number | Requirements | Responsibility ("X" indicates the columns that apply) | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | FI | RHHI | Carrier | DMERC | Shared System Maintainers | | | | Other |
| | | | | | | FISS | MCS | VMS | CWF | |
| 5139.10 | Contractors shall, per section 4.3 of the reissued chapter 10, refer to DPSE any situation where a person or entity listed on the CMS 855 has had an adverse legal action listed on section 3 of the CMS 855 imposed against him/her/it. | X | X | X | | | | | | |
| 5139.11 | Contractors shall discontinue the practice of having solely-owned practitioner organizations (as defined in section 4A of the CMS 855A) complete a CMS 855B, CMSR, and CMS 855I, as explained in section 4.4.3 of the reissued chapter 10. | | | X | | | | | | |
| 5139.12 | Contractors shall, when entering an enrollment record into PECOS, enter the names of all persons and entities listed in sections 5 and 6 of the CMS-855. | X | X | X | | | | | | |
| 5139.13 | Contractors shall note that providers can have as many authorized and delegated officials as they choose. | X | X | X | | | | | | National Supplier Clearinghouse |
| 5139.14 | Contractors shall note that the definition of "delegated official" has changed, as described in section 4.16 of the reissued chapter 10. | X | X | X | | | | | | National Supplier Clearinghouse |
| 5139.15 | Contractors shall note that sections 4 through 4.6 of the current version of chapter 10 have been consolidated into section 4.18 of the reissued chapter 10. | X | X | X | | | | | | |
| 6139.16 | Contractors shall note that ambulance suppliers are no longer required to submit information on crew members. | X | | | | | | | | |
| 5139.17 | Contractors shall abide by the instructions in section 4.18 of the reissued chapter 10 relating to hospital-based ambulances. | X | | X | | | | | | |

| Requirement Number | Requirements | Responsibility ("X" indicates the columns that apply) | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | FI | RHHI | Carrier | DMERC | Shared System Maintainers | | | | Other |
| | | | | | | FISS | MCS | VMS | CWF | |
| 5139.18 | Contractors shall, per section 4.21 of the reissued chapter 10, ensure that providers furnish all required National Provider Identifier (NPI) information when submitting CMS-855 applications. | X | X | X | | | | | | National Supplier Clearinghouse |
| 5139.19 | Contractors may accept photocopied pages of the CMS 855, as described in section 5.1 of the reissued chapter 10. | X | X | X | | | | | | National Supplier Clearinghouse |
| 5139.20 | Contractors shall not, per section 5.1 of the reissued chapter 10, accept any required information captured on the CMS 855 via telephone, letterhead, or e-mail, regardless of the relative materiality of the data element in question. | X | X | X | | | | | | National Supplier Clearinghouse |
| 5139.21 | Contractors may reject a CMS 855 application if the provider does not furnish all missing or clarifying information requested by the contractor within 60 calendar days of the date of the request, in accordance with sections 3.1 and 5.3 of the reissued chapter 10. | X | X | X | | | | | | National Supplier Clearinghouse |
| 5139.22 | Contractors shall, per section 5.3 of the reissued chapter 10, refer to DPSE any application for which the provider is unsure as to whether it should be rejected or denied. | X | X | X | | | | | | National Supplier Clearinghouse |
| 5139.23 | Contractors shall, per section 5.4 of the reissued chapter 10, handle a change in the supplier's tax identification number (TIN) as a new enrollment, thus requiring a complete CMS-855 application. | | | X | | | | | | National Supplier Clearinghouse |
| 5139.24 | Contractors may accept CMS 855A change of ownership (CHOW) applications up to three months prior to the anticipated date of the proposed ownership change. | X | X | | | | | | | |

| Requirement Number | Requirements | Responsibility ("X" indicates the columns that apply) | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | FI | RHHI | Carrier | DMERC | Shared System Maintainers | | | | Other |
| | | | | | | FISS | MCS | VMS | CWF | |
| | | | | | | | | | | |
| 5139.25 | Contractors shall continue to make Medicare payments to the old owners in a CHOW until the CHOW is approved by the RO. | X | X | | | | | | | |
| 5139.26 | Contractors shall process "full" CMS-855 applications in accordance with the instructions in section 5.7 of the reissued chapter 10. | X | X | X | | | | | | National Supplier Clearinghouse |
| 5139.27 | Contractors shall, per section 6.1 of the reissued chapter 10, inform any provider who requires regional office approval that it may take at least 6 to 9 months for the provider to obtain such approval. | X | X | X | | | | | | |
| 5139.28 | Contractors shall note that any change in the provider's phone number or address not caused by the provider (i.e., area code change, municipality renames the provider's street) does not need to be updated via the CMS 855. | X | X | X | | | | | | National Supplier Clearinghouse |
| 5139.29 | Contractors shall ensure that all initial applicants, as well as all providers who are submitting a change request but who are not receiving payments via Electronic Funds Transfer (EFT), submit a CMS-588 form. | X | X | X | | | | | | National Supplier Clearinghouse |
| 5139.30 | Contractors shall not create L & T records in the situations described in subsection D of section 15 of the reissued chapter 10. | X | X | X | | | | | | |
| 5139.31 | Contractors shall communicate with one other on PECOS "record holder" issues in accordance subsection E of section 15 of the reissued chapter 10. | X | X | X | | | | | | |

| Requirement Number | Requirements | Responsibility ("X" indicates the columns that apply) | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | FI | RHHI | Carrier | DMERC | Shared System Maintainers | | | | Other |
| | | | | | | FISS | MCS | VMS | CWF | |
| | | | | | | | | | | |
| 5139.32 | Contractors shall create a separate enrollment record for each state in its jurisdiction that the provider is enrolling in. | X | X | X | | | | | | |
| 5139.33 | Contractors shall not release any information about a provider's enrollment status to any person in the provider's organization other than an authorized official, delegated official, or contact person. | X | X | X | | | | | | |
| 5139.34 | Contractors shall not send PECOS screen prints to providers. | 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***: July 3, 2006<br><br>**Implementation Date:** July 3, 2006<br><br>**Pre-Implementation Contact(s):** Frank Whelan at 410-786-1302 or frank.whelan@cms.hhs.gov<br><br>**Post-Implementation Contact(s):** Frank Whelan at 410-786-1302 or frank.whelan@cms.hhs.gov | **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 – Provider and Supplier Enrollment

**Table of Contents**
***(Rev.150, 06-30-06)***

## *1 – Introduction to Provider Enrollment*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

*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.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

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

*Applicant means the individual (practitioner/supplier) or organization who 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 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 its 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, or the consolidation of two or more corporations, 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.*

*Deactivate 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 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 or supplier.*

*Deny/Denial means the enrolling provider or supplier 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 locations and owners; 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.*

*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 (NPPES).*

*Operational means the provider or supplier has a qualified physical practice location, is open to the public for the purpose of providing health care 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 Social Security 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 community mental health center that has in effect a similar agreement but only to furnish partial hospitalization services.*

*Reassignment means that an individual physician or non-physician practitioner, except physician assistants, has granted a clinic or group practice the right to receive payment for the practitioner's services.*

*Reject/Rejected 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.*

## *1.2 – CMS-855 Medicare Enrollment Applications*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

*The Medicare Enrollment Applications (CMS-855I, CMS-855R, CMS-855B, CMS-855A and CMS-855S) are forms issued by CMS and approved by the Office of Management and Budget (OMB). The forms collect general information about providers, suppliers and DMEPOS suppliers in order to:*

- *Ensure that the applicant is qualified and eligible to enroll in the Medicare program.*
- *Help determine the proper amount of Medicare payment.*

*The five forms are distinguished as follows:*

- *CMS-855I - This form must be completed by a physician or non-physician practitioner who renders Medicare Part B services to Medicare beneficiaries. (This includes a physician or practitioner who: (1) is the sole owner of a professional corporation, professional association, or limited liability company, and (2) will bill Medicare through this business entity.)*

- *CMS-855R - An individual who renders Medicare Part B services and seeks to reassign his or her benefits to an eligible entity must complete this form for each entity eligible to receive reassigned benefits. The person must be enrolled in the Medicare program as an individual prior to reassigning his or her benefits.*

- *CMS-855B - This application must be completed by a supplier organization (e.g., ambulance company) that will bill Medicare for Part B services furnished to Medicare beneficiaries. It is not used to enroll individuals.*

- *CMS-855A - This application must be completed by a provider (e.g., hospital) that will furnish Medicare Part A services to Medicare beneficiaries.*

- *CMS-855S - A supplier that wishes to provide Medicare beneficiaries with durable medical equipment, prosthetics, orthotics, or supplies (DMEPOS) must complete this form. The National Supplier Clearinghouse (NSC) is responsible for processing the application.*

*A separate application must be submitted for each provider/supplier type. For example, a physician who wishes to bill as a DMEPOS supplier must submit two separate applications.*

*When a prospective provider or supplier contacts the contractor to obtain a CMS-855 application, the contractor shall furnish:*

- *The Web site at which the applications can be accessed;*

- *Notification of any special documentation required for the applicant's provider/supplier type;*

- *The Medicare Authorization Agreement for Electronic Funds Transfers (Form CMS-588);*

- *The Electronic Data Interchange (EDI) agreement;*

- *The Medicare Participating Physician or Supplier Agreement (Form CMS-460), with a letter explaining the purpose of the agreement and how it differs from the actual enrollment process. (This only applies to carriers.)*

- *The contractor's address, so that the applicant knows where to return the completed application;*

- *If the applicant is a certified supplier or provider, notification that the applicant should contact the State agency for any state-specific forms and to begin preparations for a State survey. (This does not apply for those certified entities, such as FQHCs, that do not receive a State survey.) The notification can be given in any manner the contractor chooses.*

## *1.3– Medicare Contractor Duties*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

*Medicare fee-for-service contractors must adhere to the processing guidelines established in this chapter 10 (hereinafter generally referred to as "this 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 CMS,*
- *A review of the contractor's enrollment processes and procedures, and*
- *Training regarding the Provider Enrollment, Chain and Ownership System (PECOS).*

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

- *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 (ROs), as needed.*

- *Collect and maintain the application's certification statement (in house) to verify and validate Electronic Funds Transfer (EFT) changes. The change request signature must be checked against the original signature to determine the validity of any change to EFT information. This check can be made against a digital/photo image kept in-house. (See section 8 of this manual for more information.)*

- *Confirm that the applicant, all individuals 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 the Inspector General (OIG). Contractors shall confirm and validate data through Qualifier.net, the Medicare Exclusion Database (MED), and the General Services Administration (GSA) debarment list, in accordance with existing CMS instructions and directives.*

- *Confirm that enrolled providers and suppliers are reviewed monthly against the MED. This is to ensure that billing privileges are not retained by providers/suppliers that become excluded after enrollment. (Fiscal intermediaries need only perform this task on a periodic basis.)*

- *Review and investigate provider/supplier reassignments of Medicare payments to ensure full compliance with operational guidelines.*

***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.*

***Use of and Establishment of Records in PECOS***

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

## *2 – Timeliness Standards*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

*Sections 2.1 through 2.3 of this manual address the timeframes in which contractors must process CMS-855 applications.*

## *2.1 – Timeframes for Initial Applications*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

*The contractor shall process 80 percent of CMS- 855 applications within 60 calendar days of receipt, process 90 percent of CMS-855 applications within 120 calendar days of receipt, and process 99 percent of CMS-855 applications within 180 calendar days of receipt. This process generally includes:*

- *Receipt of the application in the contractor's mailroom and forwarding it to the appropriate office for review;*
- *Prescreening the application in accordance with section 3.1 of this manual;*
- *Creating an L & T record and an enrollment record in PECOS;*
- *Verification of the application in accordance with sections 5.1 through 5.7 of this manual;*
- *Requesting and receiving clarifying information in accordance with section 5.3 of this manual;*
- *Supplier site visit (if necessary);*
- *Formal notification of the contractor's decision or recommendation (and providing the appropriate appeal rights, as necessary) for approval or denial; and*

*For purposes of timeliness, the term "initial applications" also includes:*

1. *CHOW, acquisition/merger, and consolidation applications submitted by the new owner;*
2. *"Full" CMS-855 applications submitted by providers: (a) voluntarily, (b) as part of an EFT change request, (c) as part of a reactivation, or (d) as part of a revalidation.*

*(See section 5.7 of this manual for more information on the processing of "full" applications.)*

## *2.2 – Timeframes for Changes of Information*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

*The contractor shall process 80 percent of CMS-855 change of information applications within 45 calendar days of receipt, process 90 percent of such applications within 60 calendar days of receipt, and process 99 percent of such applications within 90 calendar days of receipt. This process generally includes:*

- *Receipt of the change request in the contractor's mailroom and forwarding it to the appropriate office for review;*

- *Prescreening the change request in accordance with section 3.1 of this manual;*

- *Creating an L & T record and, if applicable, tying it to an enrollment record in PECOS;*

- *Verification of the change request in accordance with sections 5.1 through 5.7 of this manual, as well as the applicable instructions in sections 7.1 and 7.2 of this manual;*

- *Requesting and receiving clarifying information in accordance with section 5.3 of this manual;*

- *Supplier site visit (if necessary);*

- *Formal notification of the contractor's decision or recommendation (and providing the appropriate appeal rights, as necessary) for approval or denial; and*

*For purposes of timeliness, the term "changes of information" also includes:*

*1. CHOW, acquisition/merger, and consolidation applications submitted by the old owner;*

*2. CMS-588 changes submitted without a need for an accompanying full CMS-855 application;*

*3. CMS-855R applications submitted independently (i.e., without being part of a CMS-855I or CMS-855B package).*

*4. CMS-855 voluntary terminations.*

## *2.3 - General Timeliness Principles*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

*Unless stated otherwise, the principles discussed below apply to all applications discussed in section 2.1 and 2.2 above (e.g., CHOW applications submitted by old and new owners, CMS-588 forms).*

***A. Clock Stoppages***

*The processing time clocks identified in sections 2.1 and 2.2 of this manual cannot be stopped or suspended for any reason. This includes, but is not limited to, the following situations:*

- *Referring an application to the Payment Safeguard Contractor (PSC) or the Office of the Inspector General (OIG);*

- *Waiting for the final sales agreement (e.g., CHOW, acquisition/merger);*

- *Waiting for the RO to make a provider-based, HHA capitalization, or CHOW determination;*

- *Referring a provider to the Social Security Administration (SSA) to resolve a discrepancy involving a social security number (SSN), as explained in section 4.2.1 of this manual.*

- *Contacting CO (e.g., DPSE) or an RO's survey/certification staff with a question regarding the application in question or CMS policy.*

*Despite the prohibition on clock stoppages and suspensions, the contractor should always document any delays by identifying when the referral to CMS, etc., was made, the reason for the referral, and when a response was received. By doing so, the contractor will be able to furnish explanatory documentation to CMS should applicable time limits be exceeded. For instance, assume a contractor received an initial CMS-855B application on March 1. On March 30, the contractor sent an adverse legal action question to CMS, and received a reply on April 7. The processing time clock did not stop from March 31 to April 7. However, the contractor should document its files to explain that it forwarded the question to CMS, the dates involved, and the reason for the referral.*

***B. Calendar Days***

*Unless otherwise stated in this manual, all days in the processing time clock are "calendar" days, not "business days." If the 60$^{th}$ day (for initials) or 45$^{th}$ day (for changes of information) falls on a weekend or holiday, this is still the day by which the application must be processed. If the contractor is unable to finish processing the application until the next business day, however, it should document the file that the 60$^{th}$ day fell on a Saturday/Sunday/holiday and furnish any additional explanation as needed.*

***C. Date-Stamping***

*As a general rule, all incoming correspondence must be date-stamped on the date it was received in the contractor's mailroom. This includes, but is not limited to:*

- *Any CMS-855 application, including initials, changes, CHOWs, etc. (The first page of the application must be date-stamped.)*

- *Letters from providers. (The first page of the letter must be date-stamped.)*

- *Supporting documentation, such as licenses, certifications, articles of incorporation, and billing agreements. (The first page of the document or the envelope must be date-stamped.)*

- *Changes of information submitted by an enrolled provider. (The first page of the application must be date-stamped.)*

- *Information furnished by the provider per the contractor's request for additional information. (All submitted pages must be date-stamped. This is because many contractors interleaf the new/changed pages within the original application; hence, it is necessary to determine the sequence in which the application and the additional pages were received.)*

*The timeliness clocks discussed in sections 2.1 and 2.2 above start on the date that the application/envelope is date-stamped in the contractor's mailroom, not when the application is date-stamped or received by the provider enrollment unit. As such, the date-stamping activities described in the aforementioned bullets must be performed in the contractor's mailroom. In cases where the mailroom staff fails to date-stamp a particular document, the provider enrollment unit may date-stamp the page in question. However, there shall not be long lapses between the time it was received in the mailroom and the time the provider enrollment unit date- stamped the pages.*

*In addition, unless stated otherwise in this manual, all incoming enrollment applications (including change requests) must be submitted via mail.*

### *D. When the Processing Cycle Ends*

*For: (1) fiscal intermediaries, and (2) carriers processing ASC or portable x-ray applications, the processing cycle ends on the date the contractor sends its recommendation for approval or denial to the State agency. In situations involving a change request that does not require a recommendation (i.e., it need not be forwarded to and approved by the State or RO), the cycle ends on the date the contractor sends notification to the provider that the change has been processed. If notification to the provider is made via telephone, the cycle ends on the date the telephone call is made (e.g., the date the voice mail message is left).*

*For carriers processing applications other than those from ASCs and portable x-ray suppliers, the processing cycle ends on the date the carrier sends its approval/denial letter to the supplier. For change request approval/denial notifications made via telephone, the cycle ends on the date the telephone call is made (e.g., the date the voice mail message is left).*

*For any application that is rejected per section 3.1 or 5.3 of this manual, the processing time clock ends on the date the contractor sends notification to the provider that the application has been rejected.*

### *E. PECOS*

*Unless stated otherwise in this manual, the contractor must create an L & T record and, if applicable, an enrollment record in PECOS no later than 15 calendar days after its receipt of the provider's application. This applies to all applications identified in sections 2.1 and 2.2 above (e.g., reassignments, CHOW applications submitted by old and new owners).*

## *3 – Pre-Screening and Application Returns*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

## *3.1 – Pre-Screening Process*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

### *A. Initial 15-Day Review*

*Within 15 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 – including, but not limited to, medical or professional licenses, certifications and registrations required by Federal or State law; NPI notification letters from NPPES; business licenses; IRS CP-575 documentation; interim sales agreements; etc. – 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 15-day period.)*

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

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

- *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. Obviously, the contractor should respond to any of the provider's telephone calls, e-mails, etc., resulting from the pre-screening letter. However, the contractor need not – on its own volition – make an additional request for the missing data or 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. (An example would be if the provider neglected to furnish its zip code but the zip code is clearly indicated on a supporting document; another illustration would be if the provider failed to check the reason why the application was submitted yet it is patently obvious to the contractor that it is an initial enrollment.)*

- ***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 5.3 of this manual for information on requesting additional (or "clarifying") information and how this is tied to the pre-screening process.*

***B. Rejection***

*In accordance with 42 CFR § 424.525(a), the contractor may reject the provider's application if the provider fails to furnish all of the information and documentation requested in the pre-screening letter within 60 calendar days of the contractor's request for the data.*

*The contractor shall also note the following with respect to rejections:*

- ***Resubmission after Rejection*** *– If the provider's application is rejected, the provider must complete and submit a new CMS-855 and all supporting documentation.*

- ***Appeals*** *– The provider may not appeal a rejection of its enrollment application.*

- ***Policy Application –*** *Unless stated otherwise in this manual, the policies contained in this section 3.1 apply to all CMS-855 applications identified in sections 2.1 and 2.2 above (e.g., changes of information, reassignments). Thus, suppose an enrolled provider submits a CMS 588. If any information is missing from the form, the contractor shall send a pre-screening letter to the provider.*

- ***Good-Faith Effort by Provider*** *- If the provider fails to submit the requested data within the aforementioned 60-day timeframe but appears to be making a good-faith effort to do so, the contractor at its discretion may continue processing the application.*

- ***Incomplete Responses*** *– The provider must furnish all missing and clarifying data requested by the contractor within the applicable timeframe. Whether the provider indeed furnished all the information is a decision that rests with the contractor. Moreover, if the provider furnishes some, but not all, of the requested data within the 60-day period, the contractor is not required to contact the provider again to request the rest of the information. The contractor has the discretion to wait until the expiration of the 60-day period and then reject the application.*

- ***Notice of Rejection*** *– If the contractor rejects the application under this section 3.1, it shall notify the provider via letter or e-mail that the application is being rejected, the reason(s) for the rejection, and how to reapply. The contractor is free to keep the original application on file after rejection. If the provider requests a copy of its application, the contractor may fax it to the provider.*

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

- ***Commencement of Timeframe*** *– The 60-day clock described above commences when the contractor mails, faxes, or e-mails the pre-screening letter.*

- ***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.*

- ***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.*

- ***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.*

*To summarize, if - during the pre-screening process - the contractor finds that data or documentation is missing, it shall send a pre-screening letter the provider within the 15-day pre-screening period. The provider must furnish all of the missing material <u>within</u> 60 calendar days of the request. If the provider fails to do so, the contractor shall reject the application.*

## *3.2 – Returning the Application*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

*The contractor shall immediately return the enrollment application to the provider in the instances described below. This policy applies to all applications identified in sections 2.1 and 2.2 of this manual:*

- *There is no signature on the application. (This includes applications that have copied or stamped signatures.)*
- *The provider submits the 11/2001 version of the CMS-855 application*
- *The application contains a copied or stamped signature*
- *The signature on the application is not dated*
- *The CMS-855I application was signed by someone other than the individual practitioner applying for enrollment.*
- *The applicant failed to submit all the forms needed to process a reassignment package within 15 calendar days of receipt (as described section 5.4 of this manual)*

- *The applicant sent its CMS-855 to the wrong contractor*
- *The applicant completed the form in pencil*
- *The applicant submitted the wrong application (e.g., a CMS-855B was submitted to a fiscal intermediary).*
- *If a Web-generated application is submitted, it does not appear to have been downloaded off of CMS's Web site.*
- *An old owner or new owner in a CHOW submitted its application more than 3 months prior to the anticipated date of the sale.*
- *The application was not mailed in (i.e., it was faxed or e-mailed).*

*The contractor need not request additional information in any of the scenarios described above. Thus, for instance, if the application was not signed, the contractor can return the application immediately.*

***NOTE** The difference between a "rejected" application and a "returned" application; the former is based on the provider's failure to respond to the contractor's request for missing or clarifying information. A "returned" application is considered a non-application.*

*If the contractor returns the application, it:*

- *Shall notify the provider via letter or e-mail that the application is being returned, the reason(s) for the return, and how to reapply.*
- *Shall <u>not</u> enter the application into PECOS. No L & T record shall be created.*
- *Any application resubmission must contain a brand new certification statement page containing a signature and date. The provider cannot simply add its signature to the original certification statement it submitted.*
- *Return all other documents submitted with the application (e.g., CMS-588, CMS 460).*

***NOTE:** For CMS-855A and CMS-855B applications, if the form is signed but it appears the person does not have the authority to do so, the contractor shall process the application normally and follow the instructions in sections 4.15 and 4.16 accordingly.*

## *4 – Application Review*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

*Sections 4.1 through 4.16 below discuss the various provisions of the CMS-855A, CMS-855B, and CMS-855I forms. Unlike previous versions of chapter 10, 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 10 in terms of the collection, processing, and verification of all data elements on the CMS-855 forms, regardless of whether the data element is specifically discussed in sections 4.1 through 4.16. In other words, the fact that a particular data element is not specifically mentioned in these sections in no way alleviates the contractor from having to collect, process, and validate that data element.*

*For purposes of brevity, the terms "approval" and "denial," as used in sections 4.1 through 4.16, also include recommendations for approval and recommendations for denial issued for certified providers and certified suppliers.*

## *4.1 – Basic Information (Section 1 of the CMS-855)*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

*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 the NPI are correct. (The NPI can be verified by reviewing the NPI notification from NPPES.)*

*Note that:*

- *If a provider is seeking to reestablish itself in the Medicare program after reinstatement from an exclusion, the provider must enroll as if it were an initial enrollment.*

- *Hospitals that are requesting enrollment with the carrier to bill practitioner services for hospital departments, outpatient locations and/or hospital clinics must submit an initial enrollment 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 manual.*

## *4.2 – Identifying Information (Section 2 of the CMS-855)*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

*Unless specifically indicated otherwise, the instructions in sections 4.2.1 through 4.2.4 below apply to the CMS-855A, the CMS-855B, and the CMS-855I.*

*The instructions in section 4.2.5 apply only to the CMS-855A; the instructions in section 4.2.6 apply only to the CMS-855B; and the instructions in section 4.2.7 only apply to the CMS-855I.*

## *4.2.1 – Tax Identification Numbers and Legal Business Names*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

*Sections 1124 and 1124A of the Social Security Act require that Medicare applicants furnish their tax identification number (TIN), as well as the TINs of all entities and persons listed in sections 5 and 6, respectively, of the CMS-855. The TIN can either be an employer identification number (EIN) or a social security number (SSN).*

*Discussed below are the procedures for verifying the EINs and SSNs of all entities and persons listed on the CMS-855. An application cannot be approved until all TINs (whether EINs or SSNs) listed on the application have been furnished and properly validated.*

*Employer Identification Numbers*

- *The contractor shall validate the applicant's EIN/TIN and legal business name against IRS paperwork, such as a CP-575, a Form 990, a quarterly tax payment coupon, or other IRS correspondence that contains this data. The documentation must be from the IRS. Applications for TINs, such as the SS-4, are not acceptable; provisional TINs are also unacceptable. Moreover, even if the applicant is a sole proprietor, he/she must submit IRS documentation if he/she lists an EIN (as opposed to the SSN) as the TIN.*

- *There may be instances where the applicant cannot obtain the required IRS documentation (e.g., the applicant recently changed its name and the IRS has not sent to it an updated document.) In such cases, the applicant must furnish an explanation in a separate attachment and provide evidence that links the legal business name with the TIN listed. One option for the applicant is to request a verification letter (IRS 147c) from the IRS that identifies its TIN and legal business name. The applicant may then submit the old IRS document with the old name, a copy of documentation filed with the State and IRS concerning the name change, and an accompanying explanation of the situation. If the applicant fails to provide this information or the data otherwise does not match, the contractor shall deny the application.*

- *If the name on the IRS documentation does not match exactly the name on the articles of incorporation, use the name on the IRS documentation as the legal business name. If there is a substantial discrepancy between the names on the two documents, the contractor shall contact the provider for clarification.*

*As for all other EINs listed on the CMS-855 (e.g., owning and managing organizations), the contractor shall use Qualifier.net as the primary review mechanism. The applicant*

*need not submit IRS documentation for these other organizations, unless the contractor specifically requests it.*

*Social Security Numbers*

*The PECOS will verify all SSNs listed on the application and entered into the system. Contractors shall not require the applicant to submit SSN tax documentation or social security cards at any point in the verification process. (Additional documentation need only be submitted when the person is doing business using a number other than its SSN. For example, an individual who forms a professional corporation or a sole proprietor who requests to use his/her EIN to receive Medicare payments must submit the IRS documentation described above.)*

*If the SSN in PECOS shows "The SSN unverified", the contractor shall request additional information. (This may clarify which data element is causing the rejection.) If the contractor determines that a number was transposed or otherwise receives a rational reason for the number not matching, it shall obtain the correct SSN and continue processing the application. If the contractor cannot resolve the case, the contractor may either (1) deny the application at that point, or (2) refer the applicant and/or the owner/manager in question to the SSA. If the latter option is chosen, the contractor shall deny the application if the individual has not resolved the matter with the SSA within a sufficient period of time. (The contractor has the sole discretion to determine what constitutes a "sufficient" period.)*

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***NOTE:** One common reason a SSN does not match is because the SSA may not have the correct surname. In situations where a female has changed her surname but has not contacted the SSA, PECOS will not validate the information. The contractor shall determine if this is the cause for the error message. If the applicant can furnish a surname used previously, the contractor shall check to see if PECOS will accept the surname. It shall also look at Qualifier.net to determine if this surname was used previously. If it was, the contractor shall continue processing the application using the previously used surname. However, the name is still required to be matched in PECOS and the matching surname must be the one listed on the CMS-855. (This may require a new certification statement. The contractor shall inform the applicant that he/she must change his/her name with the SSA. When this has been done, the CMS-855 must be updated to reflect the SSA change.)*

*The verification of the SSN is a process separate from the verification of the date of birth (DOB). Thus, if the SSN is verified but the DOB is not, the SSN is still considered verified for enrollment purposes. Conversely, even if the DOB is verified, the SSN must still be independently validated.*

*Qualifier.Net*

*The contractor must also check each SSN and EIN listed on the application against Qualifier.net - regardless of whether: (1) the SSN was validated by PECOS, or (2) the provider's EIN was verified by IRS documentation. This is to identify any SSNs or EINs*

*that may have been used previously and to spot instances where, for instance, one person may be using multiple SSNs.*

*If a number is found in Qualifier.net that differs from the number on the application, the contractor shall reconcile this issue. For example, if the executive summary shows a different name associated with the provider's EIN, the contractor shall investigate further.*

*The contractor shall deny the application if, after investigation, it determines that:*

- *The person (e.g., applicant, owner, manager, etc.) has used a different SSN in the past or is currently using multiple SSNs, even if PECOS verified the person's SSN that was listed on the form.*

- *There is insufficient evidence to link the EIN with the person or entity it is associated with on the form. For instance, suppose an owner lists its EIN in section 5 of the CMS-855. Qualifier.net lists two names next to the EIN, neither of which belongs to the owner. The contractor contacts the applicant for additional information and asks for a copy of IRS documentation verifying the owner's name and associated EIN. The applicant fails to furnish such documentation; as such, the contractor shall deny the application.*

*(See section 5.2(B) of this manual for more information on the use of Qualifier.net.)*

*Owners and Managers*

*All instances described in this section 4.2.1 where the contractor should deny the application also apply to owners, managers, etc., not just the applicant. Moreover, if an owner/manager's SSN cannot be verified and a denial is warranted, the contractor shall not give the provider the option to terminate that individual and then proceed with its existing enrollment. The provider will have to submit a new enrollment application and furnish proof acceptable to the contractor that the person no longer has a connection with the provider.*

*Certified Providers*

*There is no prohibition against two or more certified providers having the same TIN. (For instance, a company may own four HHAs, all of which are under the company's TIN.) However, each entity must enroll separately.*

## *4.2.2 – Licenses and Certifications*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

*Carriers*

*The carrier shall verify that the supplier is licensed and/or certified (whichever term is applicable to the State in question) to furnish services in:*

- *The State where the supplier is enrolling;*

- *Any other State within the carrier'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. If the carrier, in its general review of Qualifier.net, finds inconsistencies between the data on the license and the data in Qualifier.net, the carrier shall request clarifying information. (This may occur if the name on the license does not exactly match the name on the application or the name in Qualifier.net. If the carrier cannot verify that it is the same person, it shall deny the application.)*

*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 carrier shall still ensure, however, that the supplier meets all applicable State and Medicare requirements.*

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

- ***Notarization:*** *If the applicant submits a license that is not notarized or "certified true," the carrier shall verify the license with the appropriate State agency. (A notarized copy of an original document has a stamp that States "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.)*

*If the State has a licensing body that issued the applicant a certificate of good standing, the carrier shall recognize it as adequate proof that the supplier has received the license required. However, the certificate of good standing cannot be older than 30 days.*

- ***Temporary Licenses:*** *If the supplier submits a temporary license, the carrier shall note the expiration date in PECOS. Should the supplier fail to submit the permanent license after the temporary license expiration date, the carrier shall initiate revocation procedures.*

- ***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.*

*Even if the supplier furnishes the requested licensure and certification data in section 2 of the CMS-855, it must still submit a copy of all licenses and certifications.*

*Fiscal Intermediaries*

*Documents that can only be obtained after State surveys or accreditation need not be included as part of the application. The supplier must, however, furnish those documents that can be submitted prior to the survey/accreditation.*

*The intermediary 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.*

## *4.2.3 – Correspondence Address*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

*This must be an address where the contractor can directly contact the applicant to resolve any issues that may arise as a result of his/her/its enrollment in the Medicare program. It cannot be the address of a billing agency, management services organization, staffing company, or the provider's representative (e.g., attorney, financial advisor). It can, however, be a P.O. Box or, in the case of individual practitioners, 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. Contractors only need to verify that the applicant can be reached at this number. Note that mobile telephone numbers are not permitted.*

## *4.2.4 – Accreditation*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

*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 accreditation in lieu of the State survey and merely listed the accrediting body in response to the question.)*

## *4.2.5 – Section 2 of the CMS-855A*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

*Cost Reporting Data*

*If a provider is already enrolled and (1) wants to change its cost report date, and (2) is not undergoing a CHOW, it must notify CMS of this no less than 120 days prior to the close of the reporting period which the change proposes to establish. (See Pub. 15-1, Part 1, section 2414.3.)*

*If the fiscal intermediary chooses to permit this notification to be made via the CMS-855A, the fiscal intermediary shall advise the provider upon enrollment that the change must be reported in accordance with the 120-day limit, not the 90-day requirement listed on the CMS-855A. The intermediary shall document that such notice was given.*

*HHA Branches, Hospital Units, and Outpatient Physical Therapy/Occupational Therapy (OT/PT) Extension Sites*

*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 so that it shares administration, supervision, and services with the parent agency. If an existing HHA wishes to add a branch, it is considered a change of information on the CMS-855.*

*A subunit is a semi-autonomous organization under the same governing body as a parent HHA that serves patients in a geographic area different from that of the parent agency. The parent agency, because of the distance between it and the subunit, 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 or psychiatric unit, it should submit a change of information and not an initial enrollment application. If an OT/PT 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 subunit, or a hospital rehabilitation or psychiatric unit, the fiscal intermediary shall make a recommendation for approval or denial and forward the package to the State and RO. However, the fiscal intermediary shall also 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 intermediary shall create a separate enrollment record for the HHA branch or hospital unit.*

*Critical Access Hospitals*

*Critical access hospitals (CAHs) are not considered to be a hospital sub-type for enrollment purposes. Thus, if a type of hospital under section 2A2 of the CMS-855A wishes to convert to a CAH, it must complete a whole new CMS-855A as an initial enrollment.*

## *4.2.6 – Section 2 of the CMS-855B*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

*OT/PT Groups*

*Any supplier that indicates it is an OT/PT group must complete the questionnaire in section 2E. 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, it must submit a copy of the lease agreement that gives the group exclusive use of the facilities for PT/OT services. If no such lease exists, the carrier shall deny the application.*

## *4.2.7 – Section 2 of the CMS-855I*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

***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***

*The carrier shall verify all required educational information for non-physician practitioners. The non-physician practitioner must meet all Federal and State requirements and must provide documentation of courses or degrees taken to satisfy Medicare requirements. If the applicant does not meet the educational requirements, the carrier shall deny the application. The physician, moreover, must submit a copy of his/her degree with his/her application.*

***C. Residency Status***

*If the applicant is a "resident" or is in a "fellowship program," the contractor shall refer to Pub. 100-2, chapter 15, section 30.3 for further instructions.*

*Note that an intern cannot enroll in the Medicare program. Also, an individual in a residency or fellowship program cannot be reimbursed for services performed as part of that program. Thus, if the person indicates that all of his/her services will be furnished within that program, he/she cannot be enrolled.*

***D. Physician Assistants***

*As stated in the instructions on page 3 of the CMS-855I, physician assistants 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 carrier 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 be entered into PECOS as well. If an employer is excluded or debarred, the carrier shall deny the application.*

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

***E. Nurse Practitioners***

*A nurse practitioner (NP) who applied for Medicare billing privileges for the first time on or after January 1, 2001, must be a registered professional nurse who is authorized by the State in which services are furnished to practice as a NP in accordance with State law, and must be certified as a NP by a recognized national certifying body that has established standards for NPs. A NP who applied for Medicare billing privileges for the first time on or after January 1, 2003, must meet the requirements stated in the previous sentence and must possess a Master's degree in nursing.*

*Enhanced qualifications for NPs only apply to those NPs applying for Medicare numbers for the first time on or after their effective date. Enhanced qualifications will not be required for NPs already enrolled in the Medicare program on the effective date of that enhanced qualification. For NPs previously enrolled in another carrier's jurisdiction,*

*the carrier shall check the UPIN registry to verify their initial enrollment date prior to requiring that they meet any of the enhanced qualifications.*

***F. Clinical Psychologists (CPs)***

*If the applicant does not hold a doctoral degree in psychology, the carrier shall deny the application. Note that there are three different types of doctoral degrees in psychology that meet Medicare's requirements:*

***1. Ph.D. (doctorate of philosophy degree)** – This is the most common degree. The Ph.D. must be in psychology (as opposed to any other subject area). If the degree does not state "Doctor of Philosophy" followed by some specific subject area of psychology, the carrier shall follow the instructions below for verifying the doctorate.*

***2. Psy.D. (doctorate of psychology degree)** - This degree is granted by programs that lean more heavily towards preparing students for clinical practice rather than research or teaching.*

***3. Ed.D. (doctorate of education degree) -** The person's Ed.D. must be in psychology. To illustrate, having an Ed.D. in Counseling Psychology would qualify someone to seek CP status, but having an Ed.D. in educational administration or curriculum design would not. If the degree does not state "Doctor of Education" followed by some specific subject area of psychology, the carrier shall follow the instructions below for verifying the doctorate.*

*If the degree does not indicate the specialty, there are two ways that carriers can verify that the individual's doctorate is in psychology.*

*1. The carrier can check with the licensing board in each State to determine whether a doctorate in psychology is required to obtain a license to practice as a clinical psychologist. The majority of States require this level of education in order to practice psychology independently. If the carrier finds that the State requires a doctorate in psychology as a requirement for licensure as a clinical psychologist, the carrier may take the fact that the applicant has a license, along with the copy of the degree, as sufficient evidence that the applicant meets Medicare's educational requirements for a clinical psychologist. (This is the preferred method to verify that the applicant meets Medicare's educational requirements.) If the carrier chooses this method of verification, it must document in its procedures that the State licensure requirements for clinical psychologists require a doctorate in psychology. By doing so, the carrier will not need to repeat this task in the future.*

*2. The carrier can request that the applicant submit a graduate school transcript showing the concentration of study. The carrier must then review the transcript and make a subjective decision as to whether the program of study is focused in psychology. This is the least preferred method of verifying the applicant's education, as it requires*

*review of the academic transcript and determination of a field of study for each doctoral degree that does not identify the specialty area.*

*If the applicant indicated in section 2D that he/she is a clinical psychologist but checks "no" in section 2H, the carrier shall deny the application.*

***G. Psychologists Billing Independently***

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

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

*If the applicant indicates that this is his/her specialty, he/she must respond to these questions. 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. This information will be captured through the group application.*

*With respect to the questionnaire in section 2J:*

- *If the OT/PT checks that he/she renders all of his/her services in patients' homes, the carrier 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 OT/PT answers "yes" to question 2, 3, 4, or 5, he/she must submit a copy of the lease agreement that gives him/her exclusive use of the facilities for PT/OT services. If no such lease exists, the carrier shall deny the application.*

***I. Other Types of Medical Professionals***

*Registered nurses and mental health counselors cannot enroll in the Medicare program.*

## *4.3 – Adverse Legal Actions/Convictions*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

*(Unless stated otherwise, the instructions in this section 4.3 apply to the following sections of the CMS-855 application:*

- *Section 3*
- *Section 4A of the CMS-855I*
- *Section 5B (Owning and Managing Organizations)*
- *Section 6B (Owning and Managing Individuals))*

*If the applicant indicates that one of the adverse legal actions listed in section 3 has been imposed against a person or entity listed on the CMS-855, the contractor shall refer the matter to its DPSE contractor liaison for further instructions. (CMS may refer the matter to the OIG or PSC, if necessary.) The contractor shall neither approve nor deny the application until CMS issues a final directive on the matter to the contractor.*
*The only exception is if a person or entity is currently excluded or debarred. Here, the contractor shall deny the application; it need not refer the matter to DPSE prior to issuing the denial.*

*The applicant shall furnish documentation concerning the type and date of the action, what court(s) and law enforcement authorities were involved, and how the adverse action was resolved. In situations where the person or entity in question was excluded but has since been reinstated, the contractor shall verify this through the OIG and ask the applicant to submit written proof (e.g., reinstatement letter) indicating that such reinstatement has in fact taken place.*

*If the applicant states in section 3, 4A of the CMS-855I, 5, and/or 6 that the person or entity in question has never had an adverse legal action imposed against him/her/it but the contractor's review of Qualifier.Net indicates otherwise, the contractor shall contact CMS for further instructions. The contractor shall neither approve nor deny the application until CMS issues a final directive on the matter to the contractor, which could include an instruction to deny the application based on false information furnished by the applicant. (See section 6.2 of this manual.)*

*In any situation where CMS directs the contractor to deny an application based on an adverse legal action, the contactor shall notify all other contractors that have enrolled the applicant. Payment stoppages and recoupment actions may be warranted.*

## *4.4 – Practice Location Information*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

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

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

***A. Practice Location Verification***

*The contractor shall verify via Qualifier.net that the practice locations listed on the application actually exist. If a particular practice location is not shown on the executive summary, the contractor shall request clarifying information. For instance, the contractor can request that the applicant furnish letterhead showing the appropriate address.*

***NOTE:** The practice location name may be the "doing business as" name.*

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

*With respect to individual and organizational suppliers other than ASCs and portable x-ray suppliers, the carrier shall use the date in section 4A of the CMS-855B or section 4C of the CMS-855I as the date from which the applicant can bill the Medicare program. (This assumes, of course, that the supplier is approved and had a valid license as of the date listed.) In situations where the date listed appears to be beyond a reasonable amount of time (e.g., older than 12 months), the carrier shall contact the applicant by telephone and request clarifying information; it needs to ensure that the 12-month deactivation initiative will not remove the applicant from the file for any date that is used.*

***NOTE:** If an individual practitioner or group practice: (1) is adding a practice location <u>and</u> (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.*

***B. Do Not Forward (DNF)***

*(This instruction only applies to carriers at this time. The DNF initiative cannot be implemented for Fiscal Intermediary Standard System (FISS) users until a later date to be determined by CMS.)*

*The carrier shall follow the DNF initiative instructions as written in Pub. 100-04, chapter 1, section 80.5. Returned mail in the form of remittance advices and checks shall be flagged if returned from the post office, as it indicates that a change of the supplier's "special payment" address (section 4 of the CMS-855) has occurred. The supplier should thus submit a CMS-855 request to change this address; if the supplier has never completed a full CMS-855 application before, it must do so at that time.*

*Returned mail received from the post office box that is not a remittance advice or check is not considered to be DNF mail.*

*In situations where a supplier is closing his/her/its business and has a termination date (e.g., he/she is retiring), the carrier will still need to make payments for prior services rendered. Since the practice location has been terminated, the carrier may encounter a DNF message. If so, the carrier should request the supplier to complete the "special payment" address section of the CMS-855 and to sign the certification statement. The carrier, 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 Electronic Funds Transfer (EFT). The contractor shall thus ensure that the provider has signed the EFT Authorization Agreement (CMS 588), and shall verify that the bank account is in compliance with Pub. 100-04, chapter 1, section 30.2.*

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

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

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

*The contractor shall 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 may be made - might be in violation of the Payment to Agent rules in Pub. 100-04, chapter 1, section 30.2.*

## *4.4.1 – Section 4 of the CMS-855A*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

*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 listed in section 4 and the intermediary 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 hospital need not be listed as practice locations on the CMS-855A.*

*If a practice location (e.g., HHA branch, hospital unit, OPT extension site) has an OSCAR number that is in any way different from that of the main provider, the intermediary shall create a separate enrollment record in PECOS for that location. Thus, if an enrolling HHA has 5 branches, 6 enrollment records should be created – one for the main provider, and one for each of the 5 branches.*

*Home health agencies (HHAs) should complete section 4A with their administrative address.*

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

## *4.4.2 – Section 4 of the CMS-855B*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

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

*If the applicant's address or telephone number cannot be verified via Qualifier.net, 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 and proceed with its recommendation for approval or denial. However, the contractor:*

- *Shall clearly state in its recommendation letter that the facility's address and/or telephone number are not operational and hence could not be verified.*
- *Use the date the certification statement was signed as the temporary practice location "start date" in PECOS.*

*Independent Diagnostic Testing Facilities*

*If the applicant's address or telephone number cannot be verified via Qualifier.net, 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; the address and telephone number will be verified during the mandatory site visit.*

*Reassignment of Benefits*

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

## *4.4.3 – Section 4 of the CMS-855I*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

***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 carrier, 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.*

*Sole proprietorships need not 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 carrier shall verify all data furnished in section 4A (e.g., legal business name, tax identification number, adverse legal actions). If section 4A is left blank, the carrier may assume that it does not pertain to the applicant.*

***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 carrier 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 carrier shall also verify that the group is enrolled in the Medicare program. If it is not, the carrier 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), then 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 4B2 of the 855I for groups/organizations not established in PECOS with a status of "approved."*

## *4.5 – Owning and Managing Organizations*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

*(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 example illustrates the difference between direct and indirect ownership:*

*The supplier listed in section 2 of the CMS-855B is an ambulance company that is wholly (100 percent) owned by Company A. Here, 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 a 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 organization 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 regarding 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.*

- *The contractor shall review all organizations listed in section 5A against Qualifier.net. If an adverse legal action is found, the contractor shall follow the instructions in section 4.3 of this manual.*

- *Owning/managing organizations need not submit an IRS CP-575 document unless requested by the contractor (e.g., the contractor cannot confirm the organization's legal business name and tax identification number via Qualifier.net.)*

- *All owning and managing organizations listed in section 5 of the CMS-855 must be entered into PECOS.*

## *4.6 – Owning and Managing Individuals*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

*(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 manual 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, and (2) whether the partnership interest is that of a general partner or a 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.)*

- *Government entities need only list their managing employees in section 6, 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.*

- *With respect to the CMS-855I only, all managing employees at any of the applicant's 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, should not be reported.*

- *The contractor shall review all individuals listed in section 6A against Qualifier.net. If an adverse legal action is found, the contractor shall follow the instructions in section 4.3 of this manual.*

- *All owners and managers listed in section 6 of the CMS-855 must be entered into PECOS. Any previous policy that permitted contractors to enter only one managing individual into PECOS for purposes of creating an enrollment record is discontinued.*

- *Information on processing section 6B (Adverse Legal Actions) can be found in section 4.3 of this manual. Additionally, instructions on how to verify the individual's SSN can be found in section 4.2.1.*

## *4.7 – Chain Organizations*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

*(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.*

*At the current time, the fiscal intermediary 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 intermediary making its recommendation for approval or denial.*

*The fiscal intermediary 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. (The chain home office automatically qualifies as an owning/managing organization.)*

- *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.*

*The fiscal intermediary shall review both the chain home office and its administrator against Qualifier.net. If an adverse legal action is found, the contractor shall follow the instructions in section 4 of this manual.*

## *4.8 – Billing Agencies*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

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

*The provider shall complete this section with information about any and all billing agents that prepare and submit claims on its behalf. As all Medicare payments must be made via EFT, the contractor no longer needs to verify the provider's compliance with the "Payment to Agent" rules in Pub. 100-4, 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 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.*

*In all cases, the contractor shall review the billing agency and its tax identification number against Qualifier.net. (If the billing agent is an individual who does not have an EIN, the person's SSN should be reported in the TIN section.)*

## *4.9 – Reserved for Future Use*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

## *4.10 – Reserved for Future Use*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

## *4.11 – Reserved for Future Use*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

## *4.12 – Special Requirements for Home Health Agencies (HHAs)*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

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

*The fiscal intermediary shall verify that the HHA meets all of the capitalization requirements addressed in 42 CFR § 489.28. The fiscal intermediary 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.*

*If the HHA checks "yes" in section 12B, the contractor shall review the HHA nursing registry and the tax identification number against Qualifier.net.*

## *4.13 – Contact Person*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

*The contractor shall contact the individual listed in this section if it has questions regarding the information furnished on the application. If the applicant does not list or otherwise specify a contact person, the contractor shall call an authorized or delegated official. (In the case of the CMS-855I, the carrier shall contact the applicant himself/herself.) 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.*

## *4.14 – Reserved for Future Use*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

## *4.15 – Certification Statement*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

*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 supplier.*

*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 behalf of the provider, 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 authority to bind the applicant, 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., the change request encompasses two different actions).*

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

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

- *An authorized official must be an authorized official of the provider, not of an owning organization, parent company, or management company.*

## *4.16 – Delegated Officials*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

*(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 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 or supplier.*

*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 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.*

*Contractors 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 not 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.*

*The contractor has the discretion to obtain a copy of the owning/managing individual's W-2 to verify an employment relationship.*

- *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 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., the change request encompasses two different actions).*

- *The delegated official must be a delegated official of **the provider**, not of an owning organization, parent company, or management company.*

## *4.17 – Reserved for Future Use*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

## *4.18 – Ambulance Attachment*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

### *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 carrier's jurisdiction, it must submit a separate CMS-855B to each carrier.*

### *B. Licensure Information*

*With respect to licensure:*

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

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

- *The services will only be billed to the fiscal intermediary (not to the carrier); 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.*

## *4.19 – IDTF Attachment*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

*Sections 4.19.1 through 4.19.8 of this manual contain instructions regarding entities that must enroll as and bill for the technical component of diagnostic tests as an independent diagnostic testing facility (IDTF).*

## *4.19.1 – IDTF Standards*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

***A. General Principles***

*A carrier may be asked by a prospective applicant whether the latter is required to enroll as an IDTF. This is an important question, as many suppliers can perform and bill for diagnostic tests on the physician fee schedule without having to enroll as an IDTF.*

*As a general rule, an applicant that is considered to be: (1) a physician's office or (2) a part of a hospital can bill for diagnostic tests without having to enroll as an IDTF. Conversely, an applicant that operates independently from a physician's office or a hospital must enroll as an IDTF. Hence, one of the key tests in determining whether IDTF enrollment is warranted is whether the supplier is "independent."*

*Criteria in Determining "Independent" Status*

*In general, an entity should not be considered independent from a physician's office or hospital if it has the following characteristics:*

- *The entity is a physician practice that is owned - directly or indirectly - by one or more physicians or by a hospital;*

- *The entity primarily bills for physician services (e.g., evaluation and management (E & M) codes) and not for diagnostic tests;*

- *The entity furnishes diagnostic tests primarily to patients whose medical conditions are being treated or managed on an ongoing basis by one or more physicians in the practice;*

- *The diagnostic tests are performed and interpreted at the same location where the practice physicians also treat patients for their medical conditions.*

*However, that if a substantial portion of the entity's business involves the performance of diagnostic tests, the diagnostic testing services may constitute a sufficiently separate business to warrant enrollment as an IDTF. (It will be considered "independent" for purposes of enrollment). In such a case, the entity can be enrolled as a physician or a group practice of physicians, but must also enroll as an IDTF. The physician or group can bill for professional fees and the diagnostic tests they perform on their own patients using their billing number; the practice must bill as an IDTF for diagnostic tests furnished to Medicare beneficiaries who are not patients of the practice. The carrier shall advise the entity how to bill for physician office tests versus IDTF tests, and shall advise claims personnel of the dual enrollment.*

*Note that an IDTF must enroll with the carrier that has jurisdiction in the area where the beneficiary will receive the technical services of the procedure.*

***B. Radiology Offices***

*Many diagnostic tests are radiological procedures that require the professional services of a radiologist; furthermore, a radiologist's practice is generally very different from that of other physicians because radiologists usually do not bill E & M codes or treat a patient's medical condition on an ongoing basis. Nevertheless, a radiologist or a group of radiologists should not necessarily be required to enroll as an IDTF. As indicated above, the central factor is whether the radiology practice is "independent" from a physician office or hospital.*

*The following features would indicate that the radiology practice is not "independent" from a physician group or hospital:*

- *The practice is owned by radiologists, a hospital, or both;*

- *The owning radiologists and any employed or contractual radiologists regularly perform physician services (e.g., test interpretations) at the location where the diagnostic tests are performed;*

- *The entity's billing patterns indicate that it is not primarily a testing facility, and that it was organized to provide the professional services of radiologists. (To illustrate, the enrolled entity: (1) should not bill for a significant number of purchased interpretations, (2) it should rarely bill only for the technical component of a diagnostic test, and (3) it should bill for a substantial percentage of all of the interpretations of the diagnostic tests performed by the practice);*

- *A substantial majority of the radiological interpretations are performed at the practice location where the diagnostic tests are performed.*

*The carrier shall ask the applicant any and all relevant questions in order to determine whether the applicant meets the above criteria or whether the radiology group practice*

*qualifies as a radiologist's office. (This is necessary to allow the group practice of radiologists to bill for the technical component (TC) of diagnostic tests.)*

### *C. Hospitals*

*To be exempt from having to enroll as an IDTF because the applicant is a part of a hospital, the applicant should be provider-based in accordance with the provisions of 42 CFR § 413.65. Diagnostic tests billed by the hospital to its own patients and which are performed "under arrangement" do not require IDTF billings and IDTF enrollment. However, if the entity providing the "under arrangement" diagnostic tests performs diagnostic tests for which it will bill under its own billing number (as opposed to the hospital's number), the entity is subject to the IDTF rules. Therefore, the entity may or may not require enrollment as an IDTF for its own patients, subject to the guidance provided in this manual section.*

*An entity can still qualify as being "independent" (and hence be enrolled as an IDTF) even if: (1) there is joint ownership with the hospital,(2) it is located on the hospital campus, or (3) it cannot qualify as provider-based. When enrolling the IDTF, the carrier shall advise the entity on how to bill for IDTF tests versus hospital tests (including tests performed under arrangement). It shall also advise its claims personnel of the dual enrollment and shall contact the appropriate fiscal intermediary about the arrangement.*

### *D. Ambulatory Surgical Centers*

*An ASC may not bill for separate diagnostic tests they perform during the ASC's scheduled hours of operation (see 42 CFR 416.2). If an entity that owns an ASC performs diagnostic tests in the same physical facility as the ASC but during a time period when the ASC is not in operation, the entity may bill for those diagnostic tests. However, it must do so as an IDTF, thus requiring a separate IDTF enrollment.*

### *E. Portable X-Ray Suppliers*

*A mobile IDTF that provides x-ray services is not classified as a portable x-ray supplier. Therefore, it cannot bill for transportation (R0070) and setup (Q0092). If it desires to bill for these services, it must also enroll and qualify as a portable x-ray supplier and bill as a portable x-ray supplier in accordance with the portable x-ray supplier billing rules. The carrier shall ensure that an entity that is enrolled as an IDTF and a portable x-ray supplier is not double billing.*

### *F. IDTFs and Dual Enrollment*

*A currently-enrolled supplier that is not an IDTF occasionally may eventually need to also enroll as the latter (e.g., change in ownership or supervision). If the carrier believes that an enrollee requires an additional enrollment as an IDTF or a change to an existing*

*IDTF enrollment, it shall contact the supplier; the supplier may furnish evidence as to why an IDTF enrollment is not necessary. If an application is ultimately submitted, the carrier shall expedite its processing. The carrier should not make changes to the enrollee's payment status during the time period when the applicant is attempting to either: (1) furnish reasons why it is not an IDTF, or (2) obtain enrollment as an IDTF. However, if the enrollee fails or refuses to obtain required IDTF status after attempts by the carrier to expedite the process, the carrier shall commence any required payment disallowances, enrollment denials, or terminations that may be necessary to rectify the situation.*

## *4.19.2 – CPT-4 and HCPCS Codes*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

### *A. CPT-4 and HCPCS Codes*

*The CPT-4 and HCPCS codes listed should reflect those procedure codes that the applicant will perform and bill for as an IDTF.*

*If an already enrolled IDTF wants to perform additional CPT or HCPCS code tests: (1) not originally specified on its CMS-855B, and (2) that are for procedure types and supervision levels similar to its previously allowed codes, the carrier shall have the IDTF amend its CMS-855B to add the additional codes and equipment listing. A new site visit is not required. On the other hand, if the enrolled IDTF will now be performing CPT codes for <u>different</u> types of procedures, or with different supervision levels, a new site visit is required. To illustrate:*

- *A sleep laboratory is adding CPT codes for MRIs - **A new site visit is required.***
- *An imaging center that does MRIs for knees now wants to do MRIs for shoulders - **A new site visit is not required.***

*For new applicants, the carrier shall use carrier edits to restrict IDTF billings to the CPT-4 and HCPCS codes listed on the CMS-855B and that have been reviewed by the carrier. The use of carrier edits shall apply to all IDTFs that are not already enrolled as of the effective date of this change. IDTFs that have already been enrolled do not require updated carrier edits. Carriers are strongly encouraged to (but not required to) enter carrier edits for existing enrolled IDTFs as time and resource constraints permit. However, if an enrolled IDTF is performing additional CPT codes, the carrier shall enter carrier edits for all codes previously disclosed and for the new ones cited.*

### *B. Equipment*

*In conjunction with this, the carrier shall determine if the listed equipment is adequate for the tests that the applicant will perform. In other words, the carrier shall confirm that the equipment is properly calibrated and maintained by requesting and reviewing any*

*relevant documents or other evidence on the matter. This information can be obtained before, during or after a site visit. The carrier shall document the method and result of the calibration and maintenance confirmation.*

***C. Therapeutic Procedures***

*An IDTF may not bill for any CPT or HCPCS codes that are solely therapeutic.*

## *4.19.3 – Interpreting Physicians*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

*The applicant shall list all physicians for whose diagnostic test interpretations it will bill. This includes physicians who are providing purchased interpretations (which shall be in accordance with the provisions of Pub. 100-04, chapter 1, section 30.2) to the IDTF as well as physicians who are reassigning their benefits to the IDTF.*

*The carrier shall ensure and document that:*

- *All physicians listed 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 carrier may need to contact another carrier to obtain this information). If the applicant does not list any interpreting physicians, the carrier need not request additional information because the applicant may not be billing for the interpretations; that is, the physicians may be billing for themselves. However, the applicant cannot bill globally for interpreting physicians not listed.*

*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.*

*For all new enrollments and revalidations, all interpreting physicians are required to be entered into PECOS. If the interpreting physician is only enrolled with another carrier and he/she has not been entered into PECOS, the carrier shall request that the other carrier enter the interpreting physician into PECOS. The request can be made in any manner, but must be documented. The other carrier shall accomplish the PECOS entry within 30 calendar days of the request.*

## *4.19.4 – Technicians*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

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

***A. Licensure, Certification and Credentialing***

*If the technician is state-licensed or certified, the applicable license and/or certification shall be included with the application and reviewed by the carrier. A notarized or certified true copy can be accepted with no further verification needed. However, the carrier must verify non-notarized or non-certified true copies with the applicable licensing authority. (In those States where licensure or certification is not required, the supplier can check "no" in response to the question of whether the technician is State-licensed or certified.) The carrier is responsible for knowing, ascertaining, and documenting whether there are specific State licensure requirements for the tests that the technician will perform.*

*If the technician is credentialed, the applicable credentialing document shall be included with the application and reviewed by the carrier. A notarized or certified true copy can be accepted with no further verification needed. However, the carrier must verify non-notarized or non-certified true copies with the applicable credentialing authority. The carrier shall decide which organization(s) constitute a national credentialing body for the tests the technician will perform. If the credentialing body is not one that is generally recognized as acceptable for the tests being performed, the carrier shall refer the matter to the IDTF Carrier Medical Director (CMD) workgroup for their opinion. The carrier's own CMD shall facilitate this action.*

*All technicians must meet the standards of a State license, a State certification, or a national credentialing body. The only exception to this is when the following two criteria are met: (1) a Medicare payable diagnostic test is not subject to State licensure or certification of the technician performing the test, and (2) no generally accepted national credentialing body exists. In that instance, the applicant shall:*

- *Listed the technician on the CMS-855B;*

- *Submit as an attachment any educational/credentialing and/or experience that the person has; and*

- *Fully justify why the individual should be considered qualified to perform the test(s) cited.*

*Note that a letter from a supervising physician cannot serve as the sole evidence of a non-physician's qualifications to perform the tests in question. In any event, the carrier shall use its best judgment in determining whether the technician is qualified to perform the diagnostic tests the IDTF is performing.*

*The carrier shall document how and why it determined that the listed technicians listed met the licensure, certification, or credentialing requirements. All enrolling IDTFs must meet the applicable technician licensure, certification, or credentialing requirements at the time of their enrollment. Carriers shall no longer grant temporary exemptions from such requirements.*

***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 the technologist credentialing requirements at the time any tests were performed.*

*If the carrier receives notification from a technician that he/she is no longer performing tests at the IDTF, the carrier 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.*

***C. Employment Relationships***

*The IDTF technicians do not have to be employees of the IDTF. They can be contracted by the IDTF.*

*In terms of hospital employment, a technician can be employed by both an IDTF and a hospital (or other entity, including a physician practice). However, he or she cannot be scheduled to perform services for both entities at the same time. If the technician is employed by a hospital, the carrier shall notify the fiscal intermediary that is assigned to the hospital. (This is to ensure that the fiscal intermediary can confirm that the hospital is properly allocating the appropriate portion of all direct and indirect costs associated with the technician.) A technician who is employed by a hospital or physician's office does not automatically qualify as being properly credentialed to perform services for an IDTF.*

## *4.19.5 – Supervising Physicians*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

***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.*

*The carrier shall use its discretion in determining whether the supervisory physician meets the proficiency standards stated in 42 CFR § 410.33(b)(2). Supervisory physicians need not be employees of the IDTF; they can be contracted physicians for each location serviced by the IDTF.*

***B. Information about the Supervising Physicians***

*The carrier 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, and (2) is Medicare enrolled. Note, however, that the physician(s) need not be Medicare enrolled in the State where the IDTF is enrolled.*

*For all new enrollments and revalidations, all supervising physicians are required to be entered into PECOS. If the supervising physician is only enrolled with another carrier and he/she has not been entered into PECOS, the carrier shall request that the other carrier enter the supervising physician into PECOS. The request can be made in any manner, but must be documented. The other carrier shall accomplish the PECOS entry within 30 calendar days of the request.*

*In addition:*

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

- *A physician group practice cannot be considered a supervisory physician.*

- *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 carrier knows that a listed supervisory physician has been listed with several other IDTFs, the carrier 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*

*With respect to general supervision (42 CFR § 410.33(b)(1), identified above), CMS does not impose a physical distance limit between where the test is performed and where the supervisory physician is located. If the carrier questions whether a remote supervisory physician is actually performing the general supervision function, it shall ask for specific written procedures or other documentation that the IDTF has in place. Although specific written procedures are not automatically required, the IDTF – at a minimum – must furnish satisfactory answers to all of the carrier's questions.*

*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 carrier shall ensure that the IDTF's supervisory physician furnishes this level of supervision.*

*The carrier'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 above, 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 carrier may assume that the supervisory physician in question supervises for all codes listed in section 2 of the IDTF attachment – unless the carrier has reason to suspect otherwise. If Question E2 is completed, the carrier shall ensure that all codes listed in section 2 are covered through the use of multiple supervisory physicians.*

*With respect to physician verification, the carrier 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 carrier, the carrier shall contact the latter carrier and obtain the listed telephone number of the physician.)*

## *4.19.6 – Desk and Site Reviews*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

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

*The reviews shall be coordinated so that the site reviewer can ask for and/or obtain additional information that could not be developed through the desk review.*

***A. The General Site Review Process***

*A site visit should normally be conducted within the 60-day processing timeframe. If the carrier cannot perform within this timeframe because the carrier: (1) is required to visit a remote location; (2) needs to, in its judgment, perform follow-up visits; or (3) has difficulty in scheduling reviews of patients requiring direct or personal supervision, the carrier shall clearly document the reason for the delay. In no event shall the delay extend beyond the 120-day processing timeframe. Moreover, site visits should be performed on an unannounced basis, though this may not always be practical for IDTFs that are located a great distance from the site reviewer, or are mobile units.*

*The site visit may be performed by qualified employees of either the carrier or an individual or organization with which the carrier has contracted for the performance of this function. Individuals performing site visits are not required to have any specific medical training or licenses. However, the carrier shall provide any required training to ensure that the site visitor is familiar with the equipment to be verified, and the necessary qualifications of the technicians and supervisory physicians.*

*The carrier shall verify the following on the site visit:*

- *The IDTF actually exists at the location listed on the CMS-855B;*

- *One or more proficient supervisory physicians listed in Attachment 2 who furnish the required level of supervision actually exist and understand their responsibilities;*

- *Each technician listed in Attachment 2 is properly credentialed;*

- *The required test equipment listed in Attachment 2 actually exists, is properly maintained and calibrated, required for the performance of the listed tests, and is present at the IDTF.*

- *The carrier shall be present at the facility to ensure that State licensed or certified technicians listed in Attachment 2 are actually performing the listed tests;*

- *The carrier shall be present at the facility to ensure that, for tests that require personal supervision, a supervisory physician shown in Attachment 2 is actually present and with the patient;*

- *The carrier shall be present at the facility to ensure that, for tests that require direct supervision, a supervisory physician shown in Attachment 2 is within the required proximity of the patient; and*

- *For tests that require general supervision, the carrier shall:*

    - *Ask the technician the name of the supervisory physician(s) who are supervising the tests. That physician should be listed in Attachment 2.*

    - *Ask the technician how he or she can get in contact with the supervising physician(s), and confirm the technician's knowledge of procedures to follow if he or she has a problem with performing the diagnostic tests.*

    - *Ask for a copy of any procedures related to how the general supervision requirement is being met. However, written procedures are not specifically required and they can be furnished separate from the site visit. If no written procedures exist a satisfactory written response to carrier questions is required.*

*If the carrier cannot realistically perform an unannounced site visit to review the performance of services for which the IDTF will bill, the carrier may request from the IDTF a patient schedule that includes the planned tests; the carrier may then make the unannounced site visit based upon the schedule.*

*If the IDTF has more than ten practice locations but it is not a mobile unit, the carrier does not have to perform a site visit to each location. A sampling of practice locations can be performed. However, each practice location address must be verified via telephone contacts and the use of independent data validation sources.*

***B. Mobile Units***

*Mobile units are required to list their geographic service areas in section 4 on the CMS-855B. Based on the information furnished therein, the carrier shall perform a site visit via the following methods: (1) the mobile unit may visit the office of the site reviewer, or*

*(2) the site reviewer may obtain an advance schedule of the locations the IDTF will be visiting and conduct the site visit at one of those locations.*

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

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

***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 not required. The carrier shall enter carrier edits for the new procedures and any previously disclosed CPT-4 or HCPCS codes shown on previous CMS-855Bs.*

*If, however, the enrolled IDTF wants to perform additional procedures that are not similar to those previously reported (e.g., an IDTF that conducts sleep studies wants to perform ultrasound tests or skeletal x-rays), the carrier shall perform a site visit for the additional procedures. 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. When the IDTF has been reviewed and accepted for the additional procedures, the carrier shall enter carrier edits for the new procedures and any previously disclosed CPT-4 or HCPCS codes shown on previous CMS-855Bs.*

*If the enrolled IDTF originally listed only general supervision codes and was only reviewed for only general supervision tests, and now wants to perform tests that require direct or personal supervision, the carrier shall promptly suspend all payments for all codes other than those requiring general supervision. A new site visit is required to confirm that the IDTF is qualified to perform the codes requiring direct or personal supervision. 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. This determination should be made in writing and placed in the file. When the IDTF has been reviewed and accepted for the additional codes, the carrier shall enter carrier edits for the new procedures and any previously disclosed CPT or HCPCS codes shown on previous CMS-855Bs.*

*Addition of Practice Locations*

*If an enrolled IDTF that is not a mobile or portable unit wishes to add a practice location, any additional fixed practice locations must receive a site visit. The carrier shall also ascertain that the equipment at the new location is not the same equipment listed at the already enrolled locations - an exception being if the IDTF added equipment to its enrolled location to compensate for the equipment transferred to the new location.*

*Review Results*

*All findings and determinations discussed in section 2.19.6 shall be documented in writing & kept in the file. This includes, but is not limited to: (1) the results of the desk review and the site review, (2) the carrier's final decision, (3) any problems encountered, and (4) the date from which the IDTF may bill for services.*

*If the carrier uncovers any egregious conditions that may not be in accordance with Federal, State or local law (including Medicare laws and regulations), the carrier shall report them to the appropriate authority. This includes, but is not limited to, compliance with disability access rules or general health and safety violations.*

## *4.19.7 – Special Procedures and Supplier Types*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

### *A. Transtelephonic and Electronic Monitoring Services*

*Suppliers of transtelephonic and electronic monitoring services (e.g., 24-hour ambulatory EKG monitoring; pacemaker monitoring and cardiac event detection) may perform some of their services without actually seeing the patient. These billing codes include 93733, 93736, 93226, 93232, 93271, 93225, 93231, 93230, 93224, 93014, 95956, 93012, 93731, 93236, 93233, 93040, 93270, 95953 and G0004 – G0008 and G0016. Such entities should be classified as IDTFs, must meet all IDTF requirements, and shall undergo a site visit. As there are currently no specific certification standards for these entities' technicians, the carrier has the discretion to determine whether the technician has sufficient credentials.*

*If the entity lists codes G0004 – G0008, G0015, G0016, the carrier shall make a written determination that the entity has a person available on a 24-hour basis to answer telephone inquiries. (Use of an answering service in lieu of an actual person is not acceptable.) The person performing the attended monitoring should be listed in section 3 of Attachment 2, and determining the sufficiency of his/her qualifications is at the carrier's discretion. The carrier shall check that the person is available by attempting to contact the applicant during non-standard business hours; at least one of the contact calls should be made between midnight and 6:00 a.m. If the applicant does not meet the availability standard, the carrier shall deny the application.*

### *B. Slide Preparation Facilities*

*A slide preparation facility provides slide preparation and other kinds of services that are payable through the technical component of surgical pathology services; it does not furnish the professional component of surgical pathology services or other kinds of laboratory tests. As such, a slide preparation facility is not an IDTF.*

*Nevertheless, the services the facility furnishes are recognized by carriers for payment as codes in the surgical pathology code range (88300) to (88399) with a technical component value under the physician fee schedule. All enrolled slide preparation facilities shall be enrolled under specialty code 75; carriers shall convert any of these entities previously enrolled using the IDTF specialty code to the specialty code of 75.*

*Note that the services furnished by these entities are usually ordered and reviewed by a dermatologist. Slide preparation facilities generally only have one or two people performing this service.*

### *C. Radiation Therapy Centers*

*Radiation therapy centers (RTCs) furnish therapeutic services and are therefore not IDTFs. All enrolled RTCs shall be enrolled under specialty code 74. Carriers shall convert any of these entities that were previously enrolled via the IDTF specialty code to the specialty code of 74.*

### *D. 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.*

### *E. 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 carrier shall also advise its claims unit to ensure that the CLIA codes are not being billed under the IDTF provider number.*

### *F. Other Non-IDTF Providers*

*Unless indicated otherwise by the instructions in this section 2.19.7, or as otherwise directed by CMS, carriers shall not enroll via specialty code 47 any new suppliers that are not clearly IDTFs. All entities that do not meet a specific specialty code type should be enrolled as "other" or "unknown" or as instructed by CMS.*

## *4.19.8 – Billing Issues*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

### *A. Backbilling*

*Like any other non-certified supplier, an IDTF applicant may back bill from the date it met all the IDTF requirements – assuming it can furnish reasonable evidence that it indeed met the applicable standards on that date. For example, suppose an applicant was granted an IDTF number on July 1, 2005, but met all of the necessary requirements - properly calibrated equipment, qualified technicians, qualified supervisory physicians, etc. - as of May 1, 2005. The applicant can back bill for IDTF services performed on or after May 1, 2005. Evidence that the carrier shall consider in determining whether such standards were met include payroll records, personnel records, contracts, equipment purchase records, etc. The carrier, when necessary, shall request such confirming documents from the applicant or, as an alternative, may review such documents as part of the site visit. The carrier shall also document the file with the method used for determining when the applicant is entitled to bill for services. Note that the applicable personnel and equipment do not have to be the same as those of July 1, 2005.*

*An applicant that has purchased the assets of an existing IDTF is not automatically allowed to continue billing. It must apply as a new IDTF and may back bill once enrolled. Obviously, use of the same personnel and equipment as the previously enrolled IDTF can facilitate the determination that the new IDTF can bill as of the date of the sale*

### *B. Referrals*

*Nothing in this manual or the CMS-855B shall be construed to authorize billing by an IDTF, physician, physician group practice, or any other entity that violates the physician self-referral prohibition set forth in §1877 of the Social Security Act and related regulations. Carriers shall deny claims submitted in violation of §1877 and demand refunds of any payments that have been made in violation of §1877.*

*Consistent with 42 CFR § 410.32(a), the supervisory physician for the IDTF (regardless of whether the IDTF is a mobile unit) may not order tests to be performed by the IDTF unless the supervisory physician is the patient's treating physician and is not otherwise*

*prohibited from referring to the IDTF. The supervisory physician is the patient's treating physician if he or she furnishes a consultation or treats the patient for a specific medical problem and uses the test results in the management of the patient's medical problem.*

***C. Off-Site Interpretations***

*If an IDTF wants to bill for an interpretation performed by an independent practitioner off the premises of the IDTF, it must meet all instructions identified in Pub. 100-4, chapter 1, concerning purchased interpretations. In this scenario, there is no reassignment of benefits because the purchaser of the test is also considered the supplier of the test. W hen the technical component of a test is performed by the IDTF and the interpreting practitioner is the practitioner who ordered the test, the IDTF cannot bill for the interpretation. The interpreting practitioner must bill the interpretation since the IDTF cannot bill the interpretation when the interpreting physician is the referring physician.*

## *4.20 – Processing CMS-855R Applications*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

*A CMS-855R application must be completed for any individual who will:*

- *Reassign his/her benefits to an eligible entity.*
- *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.) In addition, the newly enrolling entity that is going to receive benefits must complete a CMS-855B. (See section 5.4 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 that supplier. As such, carriers 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 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 carrier shall follow the instructions in Pub. 100-04, chapter 1, section 30.2 to ensure that the 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. If either of the two signatures is missing, the carrier may return the application per section 3.2 of this manual.*

- *If the person (or group) is terminating a reassignment, either party may sign section 4; both signatures are not required. If no signatures are present, the carrier may return the application per section 3.2 of this manual.*

- *The authorized or delegated official who signs section 4 must be someone who is currently on file with the carrier 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. However, a comparison of signatures is not required.*

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

- *The carrier 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 carrier shall return the CMS-855R, with a request that the group submit a CMS-855B change request adding the new authorized official.*

## *4.21 – National Provider Identifier (NPI)*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

### *A. Submission of NPI*

*Every provider that submits an enrollment application must: (1) furnish its NPI in the applicable section of the CMS-855, and (2) submit a copy of the NPI notification it received from the National Plan and Provider Enumeration System (NPPES). (If the provider obtained its NPI via the Electronic File Interchange (EFI) mechanism, the provider shall submit a copy of the notification it received from its EFI Organization. Typically, the notice will be in the form of a letter or e-mail. In the latter case, a printout of the e-mail is fine.))*

*If the contractor detects during the pre-screening phase that any of this information is missing, it shall follow the steps in section 3.1 of this manual.*

*The aforementioned policy applies to all applications listed in sections 2.1 and 2.2 of this manual. (The only exceptions to this involve voluntary terminations, deactivations, deceased providers, and CHOW applications submitted by the old owner.) NPIs are not required in these instances.) Thus, for example, if a provider submits a change of information, it must furnish its NPI on the CMS-855, as well as a copy of its NPI notification from NPPES. If a reassignment package (as described in section 5.4 of this manual) is implicated, the NPIs and NPPES notices for all involved individuals and entities must be furnished.*

*If the provider fails to submit the mandatory NPI data, the contractor shall follow the instructions in section 3.1 of this manual.*

***B. Subparts - General***

*The contractor shall review and become familiar with the principles outlined in the "Medicare Expectations Subpart Paper," the text of which follows below*

*CMS encourages all providers to obtain NPIs in a manner similar to how they receive OSCAR numbers (i.e., a "one-to-one relationship"). For instance, suppose a home health agency is enrolling in Medicare. It has a branch as a practice location. The main provider and the branch will typically receive separate (albeit very similar) OSCAR numbers. It would be advisable for the provider to obtain an NPI for the main provider and another one for the branch – that is, one NPI for each OSCAR number.*

*Further instructions on how contractors shall deal with NPI-related matters will be issued in the near future.*

***C. Medicare Subparts Paper - Text***

## *MEDICARE EXPECTATIONS ON DETERMINATION OF SUBPARTS BY MEDICARE ORGANIZATION HEALTH CARE PROVIDERS WHO ARE COVERED ENTITIES UNDER HIPAA*

***January 2006***

***Purpose of this Paper***

*Medicare assigns unique identification numbers to its enrolled health care providers that are used to identify the enrolled health care providers in the HIPAA standard transactions that they conduct with Medicare (such as electronic claims, remittance advices, eligibility inquiries/responses, claim status inquiries/responses, and coordination of benefits) and in cost reports and other non-standard transactions.*

*This paper is a reference for Medicare carriers and fiscal intermediaries (FIs). It reflects the Medicare program's expectations on how its enrolled organization health*

*care providers who are covered entities under HIPAA1 will determine subparts and obtain NPIs for themselves and any subparts. These expectations may change over time to correspond with any changes in Medicare statutes, regulations, or policies that affect Medicare provider enrollment.*

*These expectations are based on the NPI Final Rule, on statutory and regulatory requirements with which Medicare must comply, and on policies that are documented in Medicare operating manuals but have not yet been codified. These Medicare statutes, regulations and policies pertain to conditions for provider participation in Medicare, enrollment of health care providers in Medicare and assignment of identification numbers for billing and other purposes, submission of cost reports, calculation of payment amounts, and the reimbursement to enrolled providers for services furnished to Medicare beneficiaries.*

*This paper categorizes Medicare's enrolled organization health care providers as follows:*

- *Certified providers and suppliers*
- *Supplier groups and supplier organizations*
- *Suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS)*

*This paper is not intended to serve as official HHS guidance to the industry in determining subparts for any covered health care providers other than those who are organizations and are enrolled in the Medicare program. This paper does not address health care providers who are enrolled in Medicare as individual practitioners. These practitioners are Individuals (such as physicians, physician assistants, nurse practitioners, and others, including health care providers who are sole proprietors). In terms of NPI assignment, an Individual is an Entity Type 1 (Individual) and is eligible for a single NPI. As Individuals, these health care providers cannot be subparts and cannot designate subparts. A sole proprietorship is a form of business in which one person owns all of the assets of the business and the sole proprietor is solely liable for all of the debts of the business. There is no difference between a sole proprietor and a sole proprietorship. In terms of NPI assignment, a sole proprietor/sole proprietorship is an Entity Type 1 (Individual) and is eligible for a single NPI. As an Individual, a sole proprietor/sole proprietorship cannot have subparts and cannot designate subparts.*

## ***Discussion of Subparts in the NPI Final Rule and its Applicability to Enrolled Medicare Organization Health Care Providers***

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*1 Covered entities under HIPAA are health plans, health care clearinghouses, and those health care providers who transmit any health information in electronic form in connection with a health transaction for which the Secretary of HHS has adopted a standard (referred to in this paper as HIPAA standard transactions). Most Medicare Organization health care providers send electronic claims to Medicare (they are HIPAA standard transactions), making them covered health care providers (covered entities).*

*The NPI Final Rule adopted the National Provider Identifier (NPI) as the standard unique health identifier for health care providers for use in HIPAA standard transactions. On or before May 23, 2007, all HIPAA covered entities (except small health plans), to include enrolled Medicare providers and suppliers that are covered entities, must obtain NPIs and must use their NPIs to identify themselves as "health care providers" in the HIPAA standard transactions that they conduct with Medicare and other covered entities. Covered organization health care providers are responsible for determining if they have "subparts" that need to have NPIs. If such subparts exist, the covered organization health care provider must ensure that the subparts obtain their own unique NPIs, or they must obtain them for them.*

*The NPI Final Rule contains guidance for covered organization health care providers in determining subparts. Subpart determination is necessary to ensure that entities within a covered organization health care provider that need to be uniquely identified in HIPAA standard transactions obtain NPIs for that purpose.*

*The following statements apply to **all** entities that could be considered subparts:*

- *A subpart is not itself a separate legal entity, but is a part of a covered organization health care provider that is a legal entity. (All covered entities under HIPAA are legal entities.)*
- *A subpart furnishes health care as defined at 45 CFR 160.103.*

*The following statements may relate to some or all of the entities that a Medicare covered organization health care provider could consider as subparts:*

- *A subpart may or may not be located at the same location as the covered organization health care provider of which it is a part.*
- *A subpart may or may not have a Taxonomy (Medicare specialty) that is the same as the covered organization health care provider of which it is a part.*
- *Federal statutes or regulations pertaining to requirements for the unique identification of enrolled Medicare providers may relate to entities that could be considered subparts according to the discussion in the NPI Final Rule. Medicare covered organization health care providers must take any such statutes or regulations into account to ensure that, if Medicare providers are uniquely identified now by using Medicare identifiers in HIPAA standard transactions, they obtain NPIs in order to ensure they can continue to be uniquely identified. Medicare is transitioning from the provider identifiers it currently uses in HIPAA standard transactions (for organizations, these could be OSCAR Numbers, PINs, or NSC Numbers—known as legacy identifiers or legacy numbers) to NPIs. This makes it necessary that Medicare organization health care providers obtain NPIs because the NPIs will replace the identifiers currently in use in standard transactions with Medicare and with all other health plans. In addition, Medicare organization health care providers must determine if they have subparts that need to be uniquely identified for Medicare purposes (for example, in HIPAA standard transactions conducted with Medicare). If that is the case, the subparts will need to have*

*their own unique NPIs so that they can continue to be uniquely identified in those transactions.*

- *A subpart that conducts any of the HIPAA standard transactions separately from the covered organization health care provider of which it is a part must have its own unique NPI.*

*Enrolled Medicare organization health care providers who are covered entities under HIPAA must apply for NPIs as Organizations (Entity Type 2). Organization health care providers as discussed in this paper are corporations or partnerships or other types of businesses that are considered separate from an individual by the State in which they exist. Subparts of such organization health care providers who apply for NPIs are also Organizations (Entity Type 2).*

## ***Medicare Statutes, Regulations, Manuals***

*The Social Security Act (sections 1814, 1815, 1819, 1834, 1861, 1865, 1866, and 1891) and Federal regulations (including those at 42 CFR 400.202, 400.203, 403.720, 405.2100, 409.100, 410.2, 412.20, 416.1, 418.1, 424, 482.1, 482.60, 482.66, 483, 484, 485, 486, 489, 491, and 493.12) establish, among other things, the Conditions for Participation for Medicare providers and set requirements by which Medicare enrolls providers, requires cost reports, calculates reimbursement, and makes payments to its providers. These Medicare statutory and regulatory requirements are further clarified in various Medicare operating manuals, such as the State Operations Manual and the Program Integrity Manual, in which requirements and policies concerning the assignment of unique identification numbers, for billing and other purposes, are stated.*

## ***Medicare Organization Providers and Subparts:***
## ***Certified Providers and Suppliers***

*Existing Medicare laws and regulations do not establish requirements concerning the assignment of unique identification numbers to Medicare certified providers and suppliers for billing purposes.*

***Certified Providers that bill Medicare fiscal intermediaries (hereinafter referred to as "providers"):***

- *Providers apply for Medicare enrollment by completing a CMS-855A.*
- *Most providers are surveyed and certified by the States3 prior to being approved as Medicare providers.*
- *Providers have in effect an agreement to participate in Medicare.4*

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*2 Clinical laboratory certification is handled by the Food and Drug Administration.*

3 Religious non-medical health care institutions are handled differently.

4 Community mental health centers attest to such an agreement. Religious non-medical health care institutions are handled differently.

- *Providers include, but are not limited to: skilled nursing facilities, hospitals5, critical access hospitals, home health agencies, rehabilitation agencies (outpatient physical therapy, speech therapy), comprehensive outpatient rehabilitation facilities, hospices, community mental health centers, religious non-medical health care institutions.*
- *Providers are assigned OSCAR numbers to use to identify themselves in Medicare claims and other transactions, including cost reports for those providers that are required to file Medicare cost reports.*
- *In general, each entity that is surveyed and certified by a State is separately enrolled in Medicare and is considered a Medicare provider. (An exception involves home health agency branches. The branches are not separately enrolled Medicare providers.) In many cases, the enrolled provider is not itself a separate legal entity; i.e., it is an entity that is a part of an enrolled provider that is a legal entity and is, for purposes of the NPI Final Rule, considered to be a subpart.*

***Certified Suppliers, most of which bill Medicare carriers:***

- *Certified suppliers apply for Medicare enrollment by completing a CMS-855B.*
- *Certified suppliers include ambulatory surgical centers, portable x-ray suppliers, independent clinical labs (CLIA labs), rural health centers, and federally qualified health centers.*
- *Most certified suppliers bill the carriers; however, rural health centers and federally qualified health centers bill the fiscal intermediaries.*
- *Certified suppliers are typically surveyed and certified by the States prior to being approved for enrollment as Medicare certified suppliers. (For CLIA labs, each practice location at which lab tests are performed must obtain a separate CLIA Certificate for that location, though there are a few exceptions to this.)*
- *Certified suppliers may have in effect an agreement to participate in Medicare.*
- *Certified suppliers are assigned OSCAR numbers for purposes of identification within Medicare processes. However, the carriers assign unique identification numbers to certified suppliers for billing purposes. (For CLIA labs, a CLIA Number is typically assigned to each practice location for which a CLIA certificate is issued. A CLIA Number may not be used to identify a clinical laboratory as a "health care provider" in HIPAA standard transactions. The CLIA Number has no relation to the Medicare billing number.)*
- *In many cases, the enrolled certified supplier is not itself a separate legal entity; i.e., it is an entity that is a part of an enrolled provider or certified supplier that is a legal entity and is, for purposes of the NPI Final Rule, considered to be a subpart.*

*In general, Medicare bases its enrollment of providers and certified suppliers on two main factors: (1) whether a separate State certification or survey is required, and (2) whether a separate provider or certified supplier agreement is needed. (The Taxpayer Identification Number, or TIN, is a consideration as well, though not to the degree of the two main factors.) The CMS regional offices generally make the final determinations on*

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5 Hospitals bill carriers for certain types of services.

*both of these factors; hence, Medicare provider and certified supplier enrollment policy is dictated to a significant degree by the CMS regional offices' decisions in particular cases.*

***Medicare Expectations for NPI Assignments for Providers and Certified Suppliers:*** *To help ensure that Medicare providers and certified suppliers do not experience denials of claims or delays in Medicare claims processing or reimbursement,* ***Medicare encourages each of its enrolled providers and certified suppliers to obtain its own unique NPI. These NPIs will eventually replace the legacy numbers that are used today in HIPAA standard transactions and in other transactions, such as cost reports.*** *In order for subpart determinations to mirror Medicare enrollment, each enrolled provider and certified supplier that is a covered organization health care provider would ensure the following:*

- *Obtain its own unique NPI.*
- *Determine if it has any subparts that are themselves enrolled Medicare providers. If there are subparts, ensure that they obtain their own unique NPIs, or obtain the NPIs for them. Example: An enrolled provider (a hospital) owns 10 home health agencies, all operating under the TIN of the hospital. Because the hospital and each of the 10 home health agencies is separately surveyed and enters into its own provider agreement with Medicare, a total of 11 unique NPIs should be obtained: one by the hospital, and one by each of the 10 home health agencies.*

*Regardless of how an enrolled provider or certified supplier that is a covered organization health care provider determines subparts (if any) and obtains NPIs (for itself or for any of its subparts, if they exist), Medicare payments, by law, may be made only to an enrolled provider or certified supplier.*

***Medicare Organization Providers and Subparts:***
***Supplier Groups and Supplier Organizations***

*Existing Medicare laws and regulations do not establish requirements concerning the assignment of unique identification numbers to supplier groups and supplier organizations for billing purposes.*

- *Supplier groups and supplier organizations apply for Medicare enrollment by completing a CMS-855B.*
- *Supplier groups and supplier organizations bill Medicare Part B carriers.*
- *Supplier organizations are certified by the States, or certified by the Food and Drug Administration (FDA), or must undergo an on-site inspection by the carrier. These requirements vary by type of supplier organization.*
- *Supplier groups are primarily group practices, such as a group of physicians or other practitioners.*
- *Supplier organizations include ambulance companies, mammography facilities, and independent diagnostic testing facilities (IDTFs).*

*Medicare enrolls supplier groups/supplier organizations based on Taxpayer Identification Numbers (TINs); that is, although a supplier group or supplier organization may have multiple locations, if each location operates under the same single TIN, Medicare does not separately enroll each location. There are exceptions:*

1. *When there is more than one Medicare specialty code associated with a single TIN. For instance, if a physician group practice is also an IDTF, it has two different Medicare specialties. The supplier group (the physician group practice) must enroll as a group and the supplier organization (the IDTF) must enroll as a supplier organization. The group practice would complete a CMS-855B and the IDTF would complete a CMS-855B. Each one would receive its own unique Medicare billing number.*

2. *If a separate site visit, State certification, or on-site inspection by the carrier or if FDA certification is required for each practice location of that supplier group/supplier organization.*

*In those above exceptions, Medicare separately enrolls each different Medicare specialty and each separately visited, certified or carrier-inspected practice location.*

***Medicare Expectations for NPI Assignments for Supplier Groups and Supplier Organizations:*** *To help ensure that Medicare supplier groups and supplier organizations do not experience delays in Medicare claims processing or reimbursement,* ***Medicare encourages each of its enrolled supplier groups and supplier organizations to obtain its own unique NPI. These NPIs will eventually replace the legacy numbers that are used today in HIPAA standard transactions and in other transactions, such as cost reports.*** *In order for subpart determinations to mirror Medicare enrollment, each enrolled supplier group and supplier organization that is a covered organization health care provider would ensure the following:*

- *Obtain its own unique NPI.*
- *Determine if it has any subparts that are themselves enrolled Medicare providers. If there are subparts, ensure that they obtain their own unique NPIs, or obtain the NPIs for them. Example: An enrolled IDTF has four different locations, and each one must be separately inspected by the carrier. All four locations operate under a single TIN. Because each location is separately inspected in order to enroll in Medicare, a total of four unique NPIs should be obtained: one for each location.*

*Regardless of how an enrolled supplier group or supplier organization that is a covered organization health care provider determines subparts (if any) and obtains NPIs (for itself or for any of its subparts, if they exist), Medicare payments, by law, may be made only to an enrolled supplier group or supplier organization.*

***Medicare Organization Providers and Subparts:***

## *Suppliers of Durable Medical Equipment, Prosthetics, Orthotics, or Supplies (DMEPOS)*

*Medicare regulations require that each practice location of a supplier of DMEPOS (if it has more than one) must, by law, be separately enrolled in Medicare and have its own unique Medicare billing number.*

- *A supplier of DMEPOS enrolls in Medicare through the National Supplier Clearinghouse (NSC) by completing a CMS-855S.*
- *Suppliers of DMEPOS bill Durable Medical Equipment Regional Carriers (DMERCs).*
- *Suppliers of DMEPOS include but are not limited to pharmacies, oxygen suppliers, and outpatient physical therapy agencies. (Any organization that sells equipment or supplies that are billed to Medicare through the DMERCs must be enrolled as a Supplier of DMEPOS through the NSC. Sometimes, these are organizations who also furnish services that are covered by Medicare, such as ambulatory surgical centers. In order to be reimbursed for the DME supplies that they sell, they must separately enroll in Medicare as a Supplier of DME.)*

***Medicare Expectations for NPI Assignments for Suppliers of DMEPOS:*** *Each enrolled supplier of DMEPOS that is a covered entity under HIPAA must designate each practice location (if it has more than one) as a subpart and ensure that each subpart obtains its own unique NPI.*

## ***Final Notes About NPIs***

***Enrolled organization health care providers or subparts who bill more than one Medicare contractor:*** *An enrolled organization health care provider or subpart is expected to use a single (the same) NPI when billing more than one Medicare contractor. For example, a physician group practice billing a Maryland carrier and also billing a Pennsylvania carrier would use a single (the same) NPI to bill both carriers.*

***Enrolled organization health care providers or subparts who bill more than one type of Medicare contractor:*** *Generally, the type of service being reported on a Medicare claim determines the type of Medicare contractor who processes the claim. Medicare will expect an enrolled organization health care provider or subpart to use a single (the same) NPI when billing more than one type (fiscal intermediary, carrier, RHHI, DMERC) of Medicare contractor. However, in certain situations, Medicare requires that the organization health care provider (or possibly even a subpart) enroll in Medicare as more than one type of provider. For example, an ambulatory surgical center enrolls in Medicare as a Certified Supplier and bills a carrier. If the ambulatory surgical center also sells durable medical equipment, it must also enroll in Medicare as a Supplier of DME and bill a DMERC. This ambulatory surgical center would obtain a single NPI and use it to bill the fiscal intermediary and the DMERC. Medicare expects that this ambulatory surgical center would report two different Taxonomies when it applies for its*

*NPI: (1) that of Ambulatory Health Care Facility—Clinic/Center--Ambulatory Surgical (261QA1903X) and (2) that of Suppliers—Durable Medical Equipment & Medical Supplies (332B00000X)* ***or*** *the appropriate sub-specialization under the 332B00000X specialization.*

***Enrolled organization health care providers who determine subparts for reasons unrelated to Medicare statutes, regulations or policies:***

*Consistent with the NPI Final Rule, covered organization health care providers designate subparts for reasons that are not necessarily related to Medicare statutes or regulations. If a Medicare organization health care provider designates as subparts entities other than those who are enrolled Medicare providers, and those subparts obtain their own NPIs and use those NPIs to identify themselves in HIPAA standard transactions with Medicare, those NPIs will not identify enrolled Medicare providers. Medicare is not required to enroll them. (NPI Final Rule, page 3441: "If an organization health care provider consists of subparts that are identified with their own unique NPIs, a health plan may decide to enroll none, one, or a limited number of them (and to use only the NPIs of the one(s) it enrolls."))*

*Medicare will, of course, use NPIs to identify health care providers and subparts in HIPAA standard transactions. (NPI Final Rule, page 3469: section 162.412(a): "A health plan must use the NPI of any health care provider (or subpart(s), if applicable) that has been assigned an NPI to identify that health care provider on all standard transactions where that health care provider's identifier is required.") Medicare will ensure that the NPIs it receives in HIPAA standard transactions are valid6. Medicare will reject HIPAA standard transactions that contain invalid NPIs. Valid NPIs, however, like the provider identifiers used today, must be "known" to Medicare. Medicare is not permitted to make payments for services rendered by non-Medicare providers7, nor is it permitted to reimburse providers who are not enrolled in the Medicare program. Medicare will return, with appropriate messages, any HIPAA standard transactions containing valid but unrecognizable NPIs.*

## *5 – Verification and Validation*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

*Unless stated otherwise in this manual, the instructions in sections 5 through 5.3 apply to the CMS-855A, the CMS-855B and the CMS-855I. These instructions are in addition to, and not in lieu of, all other instructions in this manual.*

## *5.1 – General Verification Principles*

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*6 The check-digit algorithm will determine the validity of an NPI. This is not the same as knowing the health care provider being identified by a particular NPI.*
*7 There may be exceptions for emergency or very unusual situations.*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

*Unless stated otherwise in this manual, the contractor shall comply with the following principles when processing CMS-855 enrollment applications:*

- ***Completeness:*** *The contractor shall ensure that the provider completed all required data elements on the CMS-855 – including all effective dates - and that all supporting documentation has been furnished. The contractor shall also ensure that the provider completed the application in accordance with the instructions on the CMS-855 form. (Note that the instructions on the CMS-855 shall be read and applied in addition to, and not in lieu of, the instructions in this manual.)*

- ***Written Data Elements:*** *Unless explicitly stated otherwise in this manual, the provider shall complete all required data elements on the CMS-855 via the application itself. The contractor shall not accept any required information captured on the CMS-855 via telephone, letterhead, e-mail, etc., regardless of the relative materiality of the data element in question.*

- ***Validation:*** *The contractor shall verify and validate all information furnished by the provider on the CMS-855. (See section 5.2 below for more information.)*

- ***Photocopying Pages*** *- The contractor may accept photocopied pages in any CMS-855 application it receives so long as the application contains an original signature. For example, suppose a corporation wants to enroll five medical clinics it owns. The section 5 data on the CMS-855B is exactly the same for all five clinics. The contractor may accept photocopied section 5 pages for these providers. However, original signatures must be furnished in section 15 of each application.*

- ***White-Out & Highlighting*** *- The contractor shall not write on, or highlight any part of, the original CMS-855 application or any supplementary pages the applicant submits. Provider usage of white-out is acceptable, although the contractor should contact the applicant to resolve any ambiguities. In addition, the contractor must determine whether the amount of white-out used on a particular application is within reason. For instance, if an entire application page is whited-out, the contractor should request that the page be resubmitted. The contractor should use its best discretion in these situations.*

## *5.2 – Verification of Data*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

*The general purpose of the verification process is to determine if any of the data furnished on the CMS-855 conflicts with Qualifier.net, supporting documentation, or any*

*other information. The contractor may begin the verification process at any time, including during the prescreening phase.*

***A. Concurrent Reviews***

*If the contractor receives multiple CMS-855s for related entities, it can perform concurrent reviews of similar data. For instance, suppose a chain home office submits initial CMS-855A applications for four of its chain providers. The ownership information (sections 5 and 6) and chain home office data (section 7) is the same for all four providers. The contractor need only verify the ownership and home office data once; it need not do it four times – once for each provider. However, the contractor shall document in each provider's file that a single verification check was made for all four files.*

*For purposes of this requirement: (1) there must be some sort of organizational, employment, or other business relationship between the entities, and (2) the applications have to have been submitted simultaneously – or at least within a few weeks of each other. As an illustration, assume that Group Practice A submits an initial CMS-855B on January 1. Group Practice B submits one on October 1. section 6 indicates that Joe Smith is a co-owner of both practices, though both entities have many other owners that are not similar. In this case, the contractor must verify Mr. Smith's data in both January and October. It cannot use the January verification and apply it to Group B's application because (1) the applications were submitted nine months apart, and (2) there is no evidence that the entities are related. (On the other hand, a CMS-855I, CMS-855B, and CMS-855R enrollment package would probably meet the two criteria above.)*

***B. Qualifier.net***

*Unless stated otherwise in this manual or in other CMS directives (e.g., JSMs), the contractor shall verify all data furnished on the CMS-855 using Qualifier.net. Such data includes, but is not limited to:*

- *State and country of birth for the provider listed in section 2 of the CMS-855I.*

- *Adverse legal history of the provider and all entities and persons listed in sections 5 and 6 of the CMS-855A.*

- *For non-certified suppliers (e.g., physician clinics), all practice locations, phone numbers, and record storage facilities listed in section 4 of the CMS-855.*

- *Legal business names and employer identification numbers of all entities listed in section 5 of the CMS-855. (Social security numbers and dates of birth are validated by PECOS – and reviewed against Qualifier.net for discrepancies – via the procedures outlined in section 4.2.1 of this manual.)*

- *Billing agency information (e.g., legal business name) listed in section 8 of the CMS-855.*

- *HHA staffing agencies (e.g., legal business name) listed in section 12 of the CMS-855A.*

*If there is a discrepancy between the information furnished by the applicant and the information on Qualifier.net, the contractor shall use alternative means to confirm the data in question. Examples of such other means include, but are not limited to:*

- ***Phone number of provider's practice location or billing agency -*** *Call the number listed on the application directly; check the Yellow Pages.*

- ***Provider's practice location -*** *Check the Yellow Pages; conduct a site visit.*

- ***Provider's "doing business as" name -*** *Review the IRS CP-575, articles of incorporation, State Web site, etc.*

- ***Legal business name or tax identification number of an entity listed in section 5 or 6 of the CMS-855*** *– Ask for a copy of the entity's CP-575.*

*If the discrepancy still cannot be resolved, the contractor shall request clarifying information from the provider to help resolve the unverifiable information.*

*Any information on the CMS-855 that is verified via supporting documentation (e.g., certifications, licenses) need not also be verified through Qualifier.net. For instance, suppose a nurse practitioner furnishes her licensure information in section 2 of the CMS-855I and includes a copy of the license as supporting documentation. The carrier need not verify the licensure data against Qualifier.net, as it has already been verified via the documentation. Other examples of data verifiable via documentation include:*

- *National Provider Identifier (NPI)*

- *Organization type listed in section 2 of the CMS-855 (e.g., corporation, limited liability company, non-profit status)*

- *Legal business name and tax identification number of the provider (e.g., IRS CP-575)*

- *Education listed in section 2 of the CMS-855I*

*In short, all information furnished on the CMS-855 must be verified via Qualifier.net, unless it is data: (1) exempted from this requirement in this manual or other CMS directive, or (2) that is verifiable via documentation submitted by the provider.*

*In addition:*

- *The contractor shall develop procedures to identify situations and patterns on Qualifier.net that might indicate fraudulent or abusive practices.*

- *All Qualifier.net executive summaries are valid for 120 days.*

- *Contractors are not required to run additional Qualifier.net searches on "AKA" names that appear on Qualifier.net.*

- *There may be instances where CMS directs contractors to verify certain data via the Medicare Exclusion Database and/or the GSA Excluded Parties List System, rather than through Qualifier.net. If a potential hit is found on the GSA List and the contractor needs to make a positive identity, it shall contact the agency that took the action for further information; based on this data, the contractor shall determine whether it is the same person. If a positive match still cannot be made, the contractor may approve the application.*

- *Contractors are not required to use the Fraud Investigation Database (FID) when processing incoming enrollment applications, including changes of information. If the contractor chooses to use the FID on a particular provider, owner, etc., and the person/entity appears on the FID, the contractor should continue to process the application. However, it should refer the matter to the PSC for guidance.*

- *In some instances, a contractor may need to contact another Medicare contractor for information regarding the provider. The latter contractor shall respond to the former contractor's request within three calendar days absent extenuating circumstances. (If the information in question involves changes to an existing PECOS record, the contractors shall follow the procedures outlined in section 15 of this manual.)*

## *5.3 – Requesting and Receiving Clarifying Information*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

### *A. Requesting Clarifying Data*

*After the completion of the 15-day 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 contains, at a minimum, the elements listed below:*

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

*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 phone number and name 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 print out the page(s) containing the data in question; enter the data on the blank page; sign and date a new, blank certification statement; and 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.)*

*If the provider fails to furnish <u>all</u> of the requested clarifications within 60 calendar days after the contractor's request, the contractor shall reject the application. It shall notify the provider via letter or e-mail that the application is being rejected, the reason(s) for the rejection, and how to reapply. The contractor is free to keep the original application on file after rejection. If the provider requests a copy of its application, the contractor may fax it to the provider.*

*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.*
- *The contractor shall not contact a provider for clarifying information until it has attempted to verify all data on the application. This will prevent the contractor from contacting the provider each time it discovers a discrepancy.*

- ***Resubmission after Rejection*** *– If the provider's application is rejected, the provider must complete and submit a new CMS-855 and all supporting documentation.*

- ***Appeals*** *– The provider may not appeal a rejection of its enrollment application.*

- ***Policy Application –*** *Unless stated otherwise in this manual, the policies enunciated in this section 5.3 apply to all CMS-855 applications identified in sections 2.1 and 2.2 above (e.g., changes of information, reassignments).*

- ***Good-Faith Effort by Provider*** *– If the provider fails to submit the requested clarification within the aforementioned 60-day timeframe but appears to be making a good-faith effort to do so, the contractor may at its discretion continue processing the application*

- ***Incomplete Responses*** *– The provider must furnish <u>all</u> clarifying data requested by the contractor within the applicable timeframe. 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 60-day period, the contractor is not required to contact the provider again to request the rest of the information. The contractor has the discretion to wait until the expiration of the 60-day period and then reject the application; however, as stated above, it should take into account any good faith efforts made by the provider to furnish the information.*

- ***Rejections vs. Denials*** *– There may be instances where a request for clarifying information involves data which, if not sufficiently resolved, warrants a denial of the application. (A common example would be SSNs and EINs.) There are two possible outcomes:*

    - *Rejection of the application under 42 CFR § 424.525(a), due to the provider's failure to furnish clarification within 60 days of the request, or*

    - *Denial of the application*

*If the contractor is faced with this situation, it shall contact its DPSE contractor liaison for guidance prior to making its decision to reject or deny.*

- ***Commencement of Timeframe*** *– The 60-day clock described above commences when the contractor mails, faxes, or e-mails the letter.*

***B. Relationship to the Pre-Screening Process***

*The contractor is free to begin the verification process during the pre-screening phase described in section 3.1 of this manual. If the contractor, in doing so, uncovers data requiring further development (e.g., problems verifying the SSN of a managing employee; Qualifier.net indicates 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 data and documentation requested in the pre-screening letter within 60 calendar days of the request, <u>and</u> (2) all clarifications asked for in the contractor's request for clarifying information within 60 calendar days of the request.*

***EXAMPLE 1:*** *The provider submits a CMS-855B 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 May 19.*

***EXAMPLE 2****: The provider submits a CMS-855B 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, though it found 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 <u>both</u> the missing data elements and the requested clarification by May 13.*

*Now suppose that the contractor had not completed the entire verification process by March 16. In its pre-screening letter, the contractor mentioned two SSN discrepancies it uncovered in the verification process thus far. 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. Here, the provider must furnish the missing information and SSN clarifications by May 13. Even if it does so, it must still provide the EIN clarifications by June 1 (or 60 days after the April 2 letter was sent). If the provider fails to comply with the March 14 letter, it may reject the application on May 13 without waiting to see if the provider can furnish the requested EIN clarifications.*

### *C. Receiving Clarifying Information*

*Unless stated otherwise in this manual, 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 fiscal intermediary. On the 58th day – one day before the intermediary planned to make its recommendation for approval – the provider on its own volition submitted updates to its section 6 data. The intermediary must process this information prior to making its recommendation, even if it takes it beyond the 60-day limit. It 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 for other applicants seeking enrollment in the Medicare program or 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.*

## *5.4 - Special Verification Procedures for CMS-855B, CMS-855I and CMS-855R Applications*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

### *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 carrier shall adhere to the instructions contained in the scenarios below. During the pre-screening process, the carrier 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 carrier 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-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 carrier 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 – If an individual who wants to enroll:*

  *(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,*

*The carrier 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 all three of the aforementioned situations, the carrier 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 carrier can return both the CMS-855B and the CMS-855I. (Note also that the 15-day clock begins when the carrier first received part of the reassignment package; in our example above, the clock commenced when the carrier received the CMS-855I.)*

*When applications are returned as described in this section 5.4, the carrier shall follow the provisions of section 3.2 of this manual in terms of notification to the provider, no creation of an L & T record in PECOS, etc. Tracking of these applications (as well as the timeliness clocks) only begins 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 carrier shall not return the application if the CMS-855R and the CMS-855B do not arrive. Rather, the carrier shall begin processing the individual's CMS-855I with respect to the practice location for the individual's practice.*

***B. Other Items***

- *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 carrier shall obtain a CMS-855B from the group. During this timeframe, the carrier shall not withhold any payment from the group. Once the group's application is received, the carrier shall add the new reassignment; if the CMS-855R was not submitted, the carrier shall secure it from the supplier.*

- *If a supplier is changing its tax identification number, it is considered 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 instructions in subsection (C) of section 5.6 of this manual shall be followed.)*

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

- *If the supplier is adding or changing a practice location and the new location is in another State within the contractor's jurisdiction, the carrier 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 carrier shall create a new enrollment record in PECOS for the new State.*

## *5.5 – Special Verification Procedures for CMS-855A Applications*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

*Unless otherwise stated, all references to the "RO" in this section 5.5 refer to the RO's survey & certification staff, not its provider enrollment personnel.*

### *A. Audit and Claims Intermediaries*

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

*When enrolling a home health agency (HHA), hospice, rural health clinic (RHC), or federally qualified health center (FQHC), the following rules apply:*

- *HHAs & Hospices – If the entity is provider-based, it shall submit its enrollment application to the parent provider's intermediary. If the entity is freestanding, the application should go to the applicable regional home health intermediary (RHHI). Regardless of whether the entity is provider-based or not, however, the claims intermediary will be the RHHI unless CMS directs otherwise.*

- *RHCs – If the entity is provider-based, it should submit its enrollment application to the parent provider's intermediary. If the entity is freestanding, the application should go to the applicable regional RHC intermediary.*

- *FQHC – All FQHC applications, whether provider-based or freestanding, shall be processed by United Government Services.*

*Thus, the audit and claims intermediaries will typically be different if the enrollee is a provider-based HHA, hospice, or RHC. In these situations, the audit intermediary (i.e., the parent provider's intermediary) shall process all changes of information, including all EFT changes. The audit intermediary shall notify the applicant during the initial enrollment process that all future changes of information must be sent to the audit intermediary, not the claims intermediary. (Quite often, a provider will submit an EFT change request to the claims intermediary 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 intermediary, the latter shall return the application per section 3.2 of this manual.*

*Once the audit intermediary finishes processing the initial enrollment application, it shall fax a copy of the application to the claims intermediary. It shall also fax copies of any future changes of information involving payment issues (e.g., EFT) to the claims intermediary once processing is complete.*

*It is imperative that the audit and claims intermediaries effectively communicate and coordinate with each other in all payment-related matters involving the provider. This includes, among other things, notifying the other intermediary whenever a tie-in or tie-out notice is received, informing the other intermediary about program integrity issues, etc.*

***B. Provider Nomination***

*As of October 1, 2005, freestanding providers entering the Medicare program may no longer express a preference for a particular fiscal intermediary. The ROs will assign these new providers to the local Blue Cross plan that serves the State or U.S. territory in which the provider is located. The term "new provider" includes situations where a change of ownership occurs but the new owner does not accept assignment of the existing provider agreement; in this situation, the provider will be assigned to the local Blue Cross plan.*

*There are several exceptions to this policy:*

- *Freestanding specialty providers, such as (but not limited to) HHAs and hospices, will continue to be assigned to their designated specialty intermediaries;*

- *Provider-based facilities will continue to be assigned to the audit intermediary that serves the parent provider, even if it is not the local Blue Cross plan.*

- *New providers that belong to or are joining CMS-recognized chains have the option to be assigned to the local Blue Cross plan or to the intermediary that services the chain home office;*

- *Providers involved in CHOWs where the new owner accepts assignment of the existing provider agreement will remain with their current intermediary, even if it is not the local Blue Cross plan.*

*In all cases, the ROs retain jurisdiction over the assignment and reassignment of providers to their respective intermediaries. If an intermediary receives a request from a provider to change its existing intermediary, it shall refer the provider to the RO contact person who handles intermediary assignments.*

***C. Changes of Ownership (CHOWs)***

*1. CHOW Definitions*

*Changes of ownership (CHOWs) are officially defined and governed by 42 CFR § 489.18 and § 3210 of the CMS State Operations Manual (SOM). The ROs make the final determination as to whether a CHOW has occurred, unless this function has been delegated.*

*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 OSCAR number and provider agreement of a provider are transferred to another entity as a result of that entity's purchase of the provider. To illustrate, suppose Entity A is enrolled in Medicare, but Entity B is not. B acquires A. In this case, A's provider agreement and OSCAR number transfer to B.*

*This is perhaps 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 OSCAR number and provider agreement. For instance, Entity A and Entity B are both enrolled in Medicare. Each entity has its own OSCAR number and provider agreement. The two entities decide to merge. Since Entity B's OSCAR number and provider agreement will be eliminated (leaving only Entity A's OSCAR number and provider agreement), a § 489.18 merger has occurred.*

*If the acquisition results in an existing provider having new owners but keeping its same provider number, the applicant should check the CHOW block.*

- ***Consolidations*** *- This occurs when two or more entities combine, creating a brand new entity. To illustrate, suppose Entities A and B (both of which are enrolled in Medicare) decide to combine and, in the process, create a new entity – Entity C. The OSCAR numbers and provider agreements of both A and B are eliminated. Entity C will have its own OSCAR 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.*

*Unless specified otherwise, the term "CHOW" as used below includes CHOWs, acquisitions/mergers and consolidations.*

*2. Determining Whether a CHOW Has Occurred*

*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 intermediary shall perform all necessary research – including reviewing the sales 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 intermediary is truly unsure as to whether a CHOW has taken place and should not be referred as a matter of course. (A RO CHOW determination is typically not required prior to the intermediary making its recommendation.) Note that a provider may undergo financial and administrative changes that it may consider to be a CHOW, but does not meet the definition shown in 42 CFR § 489.18.*

*While a CHOW is usually accompanied by a change in the tax identification number (TIN), 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 intermediary review the sales 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 intermediary reserves the right to request any information from the provider to verify this.*

*3. Processing CHOW Applications*

*The intermediary shall process CHOW applications in accordance with the following:*

- *Unless otherwise specified in this section, both the old and new owners must submit separate CMS-855A applications as well as copies of the interim and final sales agreements.*

- *Old owner – 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. Also, the creation of an enrollment record in PECOS for the old owner is not required, though an L & T record is.*

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

*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 intermediary 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 intermediary 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 intermediary ascertains that the provider accepts assignment.*

- *New owner – The intermediary shall ensure that the information contained in the sales agreement is consistent with that reported on the new owner's CMS-855A. The intermediary shall not forward a copy of the application to the State agency until it has received and reviewed the final sales agreement. It need not revalidate the information on the CMS-855A even if the data may be somewhat outdated by the time the final sales agreement is received.*

*If the old owner's CMS-855A is available at the time of review, the intermediary 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 intermediary shall contact the old owner and request it. However, the intermediary 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 intermediary 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.*

- *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 intermediary should not wait for applications from both the old and new owner to arrive before processing them. However, unless the instructions in this manual indicate otherwise, the intermediary 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 intermediary 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 intermediary may send in the applications separately, since one number is going away.)*

- *All subunits that have a separate provider agreement (e.g., HHA subunits) must submit their CHOW on a separate CMS-855A. They cannot report the CHOW via the main provider's CMS-855A.*

*If the subunit has a separate OSCAR identifier but not a separate provider agreement (e.g., hospital psychiatric unit, HHA branch), the CHOW can be reported 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.*

- *CMS-855A CHOW applications may be accepted by the intermediary up to 90 calendar days prior to the anticipated date of the proposed ownership change. Any application received more than three months in advance of the projected sale date can be returned under section 3.2 of this manual.*

- *If a final sales agreement is not submitted within 90 days after the intermediary's receipt of the new owner's application, the intermediary shall reject the application Though the intermediary must wait until the 90$^{th}$ day to return the application, the intermediary 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.*

*With respect to HHA capitalization, the intermediary need not wait 90 days to return the application, but should give the HHA a <u>reasonable</u> period of time (as defined by the intermediary) to furnish the necessary documentation.*

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

- *Medicare payments shall continue to be made to the old owners until the CHOW is approved by the RO, even if the old owner submits a CMS 588 to change the bank account to that of the new owner.*

- *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 would simply be reported as a practice location in section 4 of the new owner's CMS-855A.*

- *There may be instances where the parties in a CHOW, acquisition/merger or consolidation transaction may not have signed a "sales agreement" or "bill of sale" in the conventional sense of the term. (This may often occur with consolidations.) The intermediary may, but is not required to, accept alternative documentation, so long as such documentation furnishes clear verification of the terms of the transaction as well as all information necessary to carry out all applicable instructions pertaining to changes of ownership.*

- *When reviewing the sales agreement, the intermediary shall primarily look for: (1) consistency with the data furnished on the CMS-855A (e.g., same names), and (2) confirmation that the transaction qualifies as a CHOW.*

- *On occasion, a CHOW may be occurring in conjunction with a change to the facility's provider sub-type. This most frequently happens when a hospital undergoes a CHOW and is changing 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.*

- *Unless stated otherwise in this manual, the intermediary 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.*

*4. <u>Special PECOS Policies Regarding CHOWs</u>*

- *If a provider lists a practice location that has a different OSCAR number from the main facility (e.g., HHA branch, hospital unit, OPT extension site), the intermediary shall create a separate enrollment record in PECOS for that location (i.e., the main facility and the practice location will each have its own enrollment record).*

- *The intermediary is not required to create an enrollment record in PECOS for the old owner.*

- *The intermediary is not required to create a new L & T record in PECOS when the tie-in notice comes in, as the existing record should not be in final status and can be changed. Simply changing the L & T status is sufficient.*

- *Suppose a request for a CHOW comes in and the intermediary 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 intermediary cannot change the*

*transaction type in PECOS., it can leave the record in CHOW status but should note the provider's file that the transaction was not a CHOW.*

*5. 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-855 application, and the intermediary must create a separate enrollment record for each.*

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

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

### *A. CLIA Labs*

*Labs that are "integrated" into an existing provider or supplier do not require a separate CMS-855 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.)*

*The contractor has the discretion to determine whether a particular lab qualifies as "integrated." If it deems the lab as "integrated," the parent provider should list the lab as a practice location on the CMS-855 and furnish the applicable CLIA number.*

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

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

### *B. ASCs and Portable X-ray Suppliers (PXRs)*

*Unlike other supplier types whose applications are processed by carriers, ASCs and PXRs must receive a State survey and formal RO approval before they can be enrolled in Medicare. As such, the carrier can only make a recommendation for approval or denial to the State and the RO once it finishes reviewing the supplier's application. The carrier 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 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 carrier shall*

*enroll the ASC or PXR effective on the date shown on the notice. This is the date from which the supplier can bill for services.*

*When verifying the supplier's application, the carrier may be unable to confirm the supplier's address and/or telephone number via Qualifier.net. In such cases, the carrier shall contact the applicant for clarifying information. If the supplier states that the facility or base of operations and the phone number are not yet fully operational, the carrier may continue processing the application. The carrier shall, however, indicate in its recommendation letter that the address and telephone number of the facility could not be verified pending completion of the facility. (This same logic shall apply to situations where the applicant cannot receive a State license prior to a survey; the carrier shall not recommend denial of the application on this basis, though it should at least ask the supplier if it has a State license.)*

***C. Changes of Ownership***

*The following is a recommended (but not mandatory) procedure for processing ownership changes involving ASCs, PXRs and independent CLIA labs:*

*The ASCs, PXRs, and independent CLIA labs cannot have a formal CHOW under 42 CFR § 489.18, though various provisions of CMS's State Operations Manual allow these entities to have CHOWs under circumstances similar to those identified in 42 CFR § 489.18.*

*When ownership for one of these entities changes (as typically evidenced by the supplier's use of a new TIN), the new owner must enroll as a new supplier. The carrier shall promptly suspend payment to an ASC, PXR, or CLIA lab, but shall process the application as soon as possible. If the carrier determines that the new owner is eligible for Medicare enrollment, it shall contact the State agency to determine if there are any objections or impediments to enrollment of the new owner as a new supplier. If the State agency says it is acceptable to enroll the new owner, the carrier shall promptly enroll the supplier and pay all suspended claims. If the State agency has questions about whether the applicant must be surveyed or whether it should be licensed, the carrier shall not enroll the new applicant; rather, it shall immediately contact the RO for advice on how to handle the situation.*

*If the RO uses procedures for handling ASC, PXR, or CLIA lab changes of ownership that are different than those identified in this section 5.6(C), the carrier shall adhere to the RO's instructions.*

*If a hospital is undergoing a formal CHOW in accordance with 42 CFR § 489.18 and wants to continue billing for practitioner services, it should indicate this on the CMS-855B. (The hospital must also submit a CMS-855A to the intermediary denoting the CHOW.) If, as a result of a CHOW, the hospital wants to deactivate its billing number with the carrier, it should check "voluntary deactivation" on the CMS-855B.*

## *5.7 – Special Procedures for Processing Full CMS-855 Applications Submitted by Enrolled Providers*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

*In situations where an enrolled provider submits a full CMS-855 application: (1) voluntarily, (2) as part of a change to its EFT information, or (3) as part of a reactivation, the following rules apply:*

- *The contractor shall verify all data elements on the application in accordance with section 5.2 of this manual, just as it would with an initial enrollment application. With EFT changes, all of the data on the full application must be verified in order for the change to be approved.*

- *The applications are treated as initial applications for timeliness purposes (e.g., 80% within 60 days)). They should also be entered into PECOS as initial applications; the L & T status can be changed to "approved" once all of the data has been verified.*

- *If the enrollee is a certified supplier or certified provider, the contractor need not send a letter of recommendation to the State or RO. However, if it appears that significant data (e.g., legal business name) about the provider has changed or the contractor has reason to believe that the provider may no longer meet State or CMS requirements, the contractor should send a notification letter to the State and RO.*

- *The provider need not submit supporting documentation (e.g., licenses) with the full application, unless requested by the contractor.*

- *Sections 3.1 and 3.2 of this manual apply to the "full applications" described in this section 5.7. Thus, for instance, if the provider submits an application containing a missing signature, the contractor may return the application per section 3.2.*

# *6 – Final Application Actions*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

## *6.1 - Approvals*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

### *6.1.1 - Non-Certified Suppliers and Individual Practitioners*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

*For all supplier types enrolled with carriers – excluding ASCs and PXRs – the carrier shall notify the applicant via letter that it has been enrolled as a Medicare supplier and*

*shall forward to the applicant its Medicare billing number. The letter can be sent via postal mail or e-mail.*

*For claims submitted by physicians and non-physicians prior to the date of enrollment, the carrier shall follow the instructions in Pub. 100-4, 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 carrier should use the date that the supplier started practicing at the practice location as the date it can begin submitting claims.*

## *6.1.2 - Certified Providers and Certified Suppliers*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

*(This section only applies to: (1) fiscal intermediaries when processing initial CMS-855A applications or CHOW, acquisition/merger, or consolidation applications submitted by the new owner; and (2) carriers 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 do the following:*

- *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;*
    - *OSCAR Number (if available);*
    - *Type of enrollment transaction (CHOW, initial enrollment, branch addition, etc.);*
    - *Carrier/Intermediary Number;*
    - *Carrier/Intermediary Contact Name;*
    - *Carrier/Intermediary 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.*

- *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.*

- *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 intermediary 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 intermediary 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 the 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 should also be told that all questions related to this process shall be directed to the State agency and/or RO.*

## *6.2 – Denials*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

*Per 42 CFR §424.530(a), carriers must deny, and intermediaries must recommend a denial of, an enrollment application if any of the situations described below are present. (Carriers should only recommend denial in the case of ASCs and portable x-ray suppliers.) The carrier/RO must provide appeal rights. A denial is effective 30 calendar days after the contractor sends its denial notice to the provider.*

*Denial Reason 1 (42 CFR §424.530(a)(1))*

*The provider or supplier is determined not to be in compliance with the enrollment requirements described in this section or in the enrollment application applicable for its provider or supplier type and has not submitted a plan of corrective action as outlined in part 488 of this chapter.*

*Denial Reason 2 (42 CFR §424.530(a)(2))*

*The provider or supplier, or any owner, managing employee, authorized or delegated official, medical director, supervising physician, or other health care personnel of the provider or supplier who is required to be reported on the CMS-855 is—*

- *Excluded from the Medicare, Medicaid, or any other Federal health care program, as defined in 42 CFR §1001.2, in accordance with section 1128, 1128A, 1156, 1842, 1862, 1867 or 1892 of the Social Security Act, or*

- *Debarred, suspended, or otherwise excluded from participating in any other Federal procurement or nonprocurement program or activity in accordance with section 2455 of the Federal Acquisition Streamlining Act.*

*Denial Reason 3 (42 CFR §424.535(a)(3))*

*The provider, supplier, or any owner of the provider or supplier was, within the 10 years preceding enrollment or revalidation of enrollment, convicted of a Federal or State felony offense that CMS has determined to be detrimental to the best interests of the program and its beneficiaries. Offenses include--*

- *Felony crimes against persons, such as murder, rape, assault, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions.*

- *Financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions.*

- *Any felony that placed the Medicare program or its beneficiaries at immediate risk, such as a malpractice suit that results in a conviction of criminal neglect or misconduct.*

- *Any felonies that would result in mandatory exclusion under section 1128(a) of the Social Security Act.*

*Denial Reason 4 (42 CFR §424.530(a)(4))*

*The provider or supplier certified as "true" false or misleading information on the enrollment application to be enrolled or maintain enrollment in the Medicare program. (The contractor shall contact its DPSE contractor liaison prior to issuing or recommending denial of an application on this ground.)*

*Denial Reason 5 (42 CFR §424.530(a)(5))*

*The CMS determines, upon onsite review or other reliable evidence, that the provider or supplier is not operational to furnish Medicare covered items or services, or does not meet Medicare enrollment requirements to furnish Medicare covered items or services. This includes the following situations:*

- *The applicant does not have a license(s) or is not authorized by the Federal/State/local government to perform the services for which it intends to render. (In the denial letter, the contractor shall list the appropriate citations, e.g., §1861(r) or §1861(s) of the Social Security Act.)*

- *The applicant does not have a physical business address or mobile unit where services can be rendered and/or does not have a place where patient records are stored to determine the amounts due such provider or other person (as set forth in §1833(e) of the Social Security Act.)*

- *The applicant does not meet CMS regulatory requirements for the specialty. (In the denial letter, the contractor shall list the appropriate regulation citation.)*

- *The applicant does not qualify as a provider of services or supplier of medical and health services. An entity seeking Medicare payment must be able to receive reassigned benefits from physicians in accordance with the Medicare reassignment statute in §1842(b)(6) of the Act (42 U.S.C. 1395u(b)).*

- *The applicant does not provide a valid SSN/EIN for the applicant, owner, partner, managing organization/employee, officer, director, ambulance crewmember, medical director, and/or delegated or authorized official.*

- *A home health agency (HHA) does not meet the capitalization requirements per 42 CFR § 489.28.*

*When a decision to deny is made, the carrier shall send a letter to the supplier identifying the reason(s) for denial and furnishing appeal rights. The letter shall follow the format of that shown in section 14 of this manual.*

*If a recommendation to deny is made (for certified suppliers and providers), the contractor shall send a letter of recommendation for denial to the applicable State agency, with a copy going to the RO's survey and certification unit. The letter shall contain the same data elements listed in section 6.1.2 of this manual; the contractor shall also follow the same procedures for furnishing notification to the State, the RO, and the provider identified in section 6.1.2 above.*

*It is imperative that all denial (or recommendation for denial) letters contain sufficient factual and background information so that the reader understands exactly why the denial occurred. It is not enough to simply list one of the eight denial reasons. For instance, if an application is denied based on falsification, the carrier must identify in its*

*letter the falsified information, how and why the carrier determined it was false, etc. If there were multiple reasons for denial, the letter shall state as such.*

*A provider or supplier that is denied enrollment in the Medicare program cannot submit a new enrollment application until the following has occurred:*

- *If the denial was not appealed, the provider or supplier may reapply after its appeal rights have lapsed.*

- *If the denial was appealed, the provider or supplier may reapply after it received notification that the determination was upheld.*

*If the denial was due to adverse activity (sanction, exclusion, debt, felony) of an owner, managing employee, an authorized or delegated official, medical director, supervising physician, or other health care personnel of the provider or supplier furnishing Medicare services, the denial may be reversed if the provider or supplier submits proof that it has terminated its business relationship with that individual or organization within 30 days of the denial notification. The contractor, however:*

- *Need not solicit or ask for such proof in its denial letter. It is up to the provider to furnish this data on its own volition.*

- *Has the ultimate discretion to determine whether sufficient "proof" exists.*

## *7– Changes of Information*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

*Unless indicated otherwise, the instructions in this section 3.7 apply to carriers and fiscal intermediaries.*

## *7.1 – General Procedures*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

*Unless otherwise specified in this manual, if an enrolled provider is adding, deleting, or changing information under its same 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 addition:*

- ***Unsolicited Additional Information*** *- Any new or changed information submitted by a provider prior to the date the contractor finishes processing a change request is considered an update to that original change request. It is not considered to be a*

*separate change of information. Thus, suppose a provider submits a change of information. On the 24th day, it submits more information that it wants changed. Because the contractor had 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*** *- 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) does not need to be updated via the CMS-855. The provider shall send a letter to the contractor identifying the change and the facilities involved, and must furnish evidence satisfactory to the contractor that the change was not of its own doing. (Note that this is the only exception to the rule that all changes must be reported via the CMS-855 application.) When inputting this data into PECOS, the contractor should create an L & T record for each change so as to ensure that it gets credit for the work it performed.*

*If the contractor becomes aware on its own volition of a zip code or telephone area code change in a particular geographic area, it may forgo the requirement that the provider furnish this information to the contractor and simply make the change on its own without contacting the provider.*

- ***Denials of Change Requests –*** *The contractor shall deny (or recommend denial of) a provider's change request if any of the situations identified in section 6.2 above are implicated. In the case of a certified supplier or certified provider, the contractor shall send the recommendation for denial to the State and RO if the change involves any of the situations identified in the previous bullet (e.g., stock transfer, addition of practice location.)*
- ***Verification of Signatures/Section 6*** *– Unless the change request involves a change to EFT information, the contractor is not required to verify signatures for changes of information (e.g., matching the authorized or delegated official's signature on the change request against that same official's signature already on file). However, 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 Qualifier.net and note in the enrollment file that this was performed. This policy applies regardless of whether the provider has a CMS-855 on file already.*

- ***Notifications*** *– For changes of information that do not involve or require RO approval (e.g., CMS-855I changes, CMS-855B changes not involving ASCs or portable x-ray suppliers, 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 10 of this manual) in the file the date and time the confirmation was made. In certain situations, the contractor has discretion when making this contact. For example, where an area code/zip code has been changed for the entire community, it is not necessary to send confirmation to the provider that this change has been made. .*

## *7.2 - Special Instructions for Certified Providers, ASCs, and Portable X-ray Suppliers*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

*Unless stated otherwise, the instructions in this section 7.2 apply to certified providers, ASCs, and portable x-ray suppliers:*

- ***Post-Recommendation Changes*** *- On occasion, an applicant may submit a change request after the contractor makes its recommendation on the applicant's initial CMS-855 but before the RO issues a tie-in notice (or approval notice). In these cases, the contractor shall still process the change request in accordance with existing instructions. That is, any changed or corrected information submitted after the contractor makes its recommendation but before the tie-in notice is issued shall be processed as a change request. The contractor shall not simply take the changed information/corrected pages and, immediately upon receipt, send them directly to the State/RO to be incorporated into the existing application. However, the contractor need not enter the change request into PECOS until the tie-in notice is issued.*

- ***Critical Access Hospitals (CAHs)*** *- An increasing number of hospitals are converting to CAHs. The intermediary will sometimes receive a tie-in notice authorizing the conversion; however, the provider never completed a CMS-855A change of information request. (In other words, the provider went directly to the State/RO and bypassed the intermediary and the CMS-855 process.) In such a situation, the intermediary shall have the provider complete a new CMS-855A enrollment application. (See section 4.2.5 of this manual for more information on CAHs.)*

*This principle also applies to changes of information, such as the addition of a HHA branch, hospital sub-unit, or even an ASC practice location. If the contractor receives a tie-in notice or approval notice and no CMS-855 change of information was completed, the contractor shall have the provider submit one.*

- ***RO Approval Needed*** *- A few change of information requests require: (1) a recommendation for approval/denial, (2) referral to the State/RO, and/or (3) a tie-in/tie-out notice or other type of RO approval Conversely, some changes are so minor that there is no real need to refer the matter to the State or RO.*

*The following is a list of transactions that should be accompanied by a recommendation and referral to the State/RO (unless the RO specifies otherwise). Note that this list is not necessarily exhaustive:*

- *The addition/subtraction of a practice location, regardless of whether a tie-in or tie-out notice would normally be issued. This would include any change in the address of an existing practice location as well as the addition of a HHA branch or psych/rehab unit.*

- *Change in hospital type (e.g., from long-term to acute care) not involving a critical access hospital.*

- *Large-scale stock transfers. These situations usually do not qualify as CHOWs, but the State/RO might want to be advised of the situation.*

- *Change in the legal business name or TIN that does not involve a CHOW.*

- *Changes in adverse legal history, such as a recent criminal conviction.*

*Most other transactions do not require a recommendation and referral to the State/RO. The contractor can simply notify the provider via letter, e-mail, or telephone that the change has been made; it need not send a copy of the notification to the State or RO. However, because each RO may have different policies as to those changes it wishes to review and/or issue tie-in/tie-out notices, contractors are strongly advised to contact the applicable RO(s) to specifically identify those change requests that should be referred to the RO, as well as to find out whether the RO will issue a formal approval notice. This will also dictate when the PECOS status can be flipped to "approved." Thus, if the contractor confirms that a particular change request does not require notification of the State/RO or does not otherwise need State/RO approval, the contractor can "flip" the PECOS status to "approved" once the change has been processed. For cases where a tie-in or RO approval is required, the contractor shall process the change but not switch the record's status to "approved" until such approval has been received from the RO.*

*If the contractor refers a matter to the State/RO and has not received a tie-in or other notice signifying that the change has been approved, it should contact the RO to see if approval is forthcoming.*

*In situations where the provider has no CMS-855 on file and submits a full one as part of a change of information (e.g., EFT change), it is not automatically necessary to send the application to the State and RO. Whether or not a recommendation for approval and referral to the State/RO is required depends on what the underlying change involves. For instance, if the provider was only submitting a change of EFT information, this can be approved without a referral. If the provider was adding a HHA branch, however, and the provider agrees to submit an entire CMS-855 in the process, the intermediary should make a recommendation and refer it to the State. (The intermediary should forward the whole application to the State with a note stating that the only matter the State needs to consider is the branch addition.)*

- ***Audit vs. Claims Intermediaries*** *- In situations where the audit intermediary differs from the claims intermediary – as might happen with a provider-based HHA, where the provider's intermediary is the audit intermediary and the RHHI is the claims intermediary – the audit intermediary is responsible for processing all changes of information, including all EFT changes. The audit intermediary should therefore notify the applicant during the initial enrollment process that all future change of information requests must be sent to the audit intermediary, not the claims intermediary. (Quite*

*often, a provider will submit an EFT change request to the claims intermediary because the latter processes the provider's claims.) If the provider inadvertently sends a change of information request to the claims intermediary, the claims intermediary shall return the change request to the provider per section 3.2 of this manual.*

- ***Chain Organizations*** *- Per Pub. 100-4, chapter 1, section 30.2, a chain organization may have payments to its providers 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 they each want to change their EFT account to that of the chain home office, 100 separate CMS 588s must be submitted, unless CMS dictates otherwise. If any of these chain providers have never completed a CMS-855 before, they must do so at that time.*

- ***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.*

- ***Practice Locations in Multiple States or Contractor Jurisdictions***

  - *If the provider wants to add a practice location in the same State as the main facility, and the location requires a separate provider agreement, a separate enrollment for the location is required.*

  - *If the provider wants to add a practice location in a State different from that of the main provider, and the location requires a separate State survey and/or provider agreement, a separate enrollment for the location is required. (For HHAs, if the HHA wants to furnish services in a neighboring State, and the RO or applicable State laws require a separate State survey or provider agreement, a separate enrollment is required.) In some cases, States may have "reciprocity agreements" whereby one State will recognize the laws of another State as being applicable to the new practice location in its State – meaning, in essence, that the provider may practice in the new State without having to necessarily meet certain of that State's requirements.*

  - *If the provider wants to add a practice location or perform HHA services in a State different from that of the main facility, and the provider is not enrolled with the intermediary or RHHI in that State, the provider must submit a complete CMS-855A for that State – regardless of whether a separate State survey and/or provider agreement is required.*

*The provider has the ultimate responsibility for finding out whether a particular practice location (whether in-state or out-of-state) requires a separate survey or agreement. If the contractor has concerns as to whether a listed practice location indeed requires a separate survey or agreement, it should contact the State or RO.*

- ***Hospital Adds Practice Location***

  - *In situations where the hospital is adding a practice location, the intermediary 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.*

## *7.3 – Voluntary Terminations*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

*Voluntary terminations shall be processed in accordance with the timeframes in section 2.2 of this manual (e.g., 80 percent within 45 calendar days).*

*If the termination involves a certified provider, ASC, or portable x-ray supplier, the contractor shall make a recommendation to the State and RO. The contractor shall not terminate the provider in its system until the RO issues its final approval of the matter.*

## *8 – Electronic Fund Transfers (EFT)*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

*If a provider that has never completed a CMS-855 before wants to make any change to any of its EFT information (e.g., bank routing number), it must complete the CMS-855 form in its entirety before the contractor can effectuate the change. (It is immaterial whether the provider or the bank (e.g., change in bank name via merger) was responsible for triggering the changed data.) The contractor shall return the change request to the provider with the instruction that the provider must complete the entire application. The return shall be done in accordance with, and in the manner described in, section 3.2 of this manual.*

*(**NOTE**: The only exception to the aforementioned requirement that a full application be completed if the provider has never completed a CMS-855 before is if the signer already has a signature on file with the contractor. In these cases, only the CMS-588 is needed.)*

*The contractor need not obtain attachments (e.g., licenses) from these providers that are submitting a full CMS-855 application, though a new CMS 588 is obviously required if the provider is changing its EFT information. However, the provider must submit a complete enrollment application.*

*Once the provider submits the full application, the contractor should attempt to process the change as expeditiously as possible so as to ensure that there is no interruption in payment. The contractor shall verify all data elements on the CMS-855, just as it would with an initial enrollment application; it shall not approve the EFT change until all data on the CMS-855 has been validated.*

*In addition:*

- ***Mandatory Use of EFT*** *- All providers entering the Medicare program for the first time must use EFT in order to receive payments. Moreover, any provider not currently on EFT that submits any change to its existing enrollment data must also submit a CMS-588 form to convert to EFT.*

- ***Verification*** *- The contractor shall verify that all EFT changes must comply with Pub. 100-04, chapter 1, section 30.2.5, Payment to Bank.) In short, all EFT changes must be verified and validated.*

- ***Sent to the Wrong Unit*** *- If a provider submits its EFT change request to the contractor but not to the latter's enrollment unit, the recipient unit shall forward it to the enrollment unit, 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.*

- ***CMS 588 Changes and PECOS*** *– In situations where the only data the provider is changing is on the CMS 588 (e.g., no data is changing on the CMS-855), the contractor shall process the EFT change as a change of information. However, it shall not create an L & T record.*

- ***Processing Timeframes*** *- In situations where the provider has never completed a full application and does so as part of its EFT change request, the contractor shall process the application within the same timeframes specified in section 2.1 of this manual for initial applications (i.e., 80 percent within 60 calendar days). It shall be treated as an initial enrollment for reporting purposes. The processing clock does not start until the full application is received in conjunction with the change request.*

*In situations where the provider already has a CMS-855 on file and submits an EFT change, the change request shall be treated like any other change request for purposes of timeliness (i.e., 80 percent within 45 calendar days).*

- ***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.*

*If the person's signature is not already on file, the contractor shall request that the individual 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.)*

- ***Suspicious Changes*** *- It is not necessary – as a matter of course – for contractors to review the provider's recent claims activity prior to approving a change in EFT data. Contractors should, however, review the provider's recent claims activity if it has*

*suspicions about the propriety of the change request. If necessary, the contractor can refer the matter to the PSC for its information.*

- ***Bankruptcies and Garnishments*** *– In general, all court orders take precedence over the instructions in this manual. However, if the contractor receives a copy of a court order to send payments to a party other than the provider, the contractor shall contact the RO's Office of General Counsel.*

*In situations where a non-certified supplier (e.g., physician, ambulance company) voluntarily withdraws from Medicare and needs to obtain its final payments, the carrier shall send the payments to the provider's EFT account of record. If the account is defunct, the carrier can send it to the provider's "special payments" address or, if none is on file, 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.*

## *9 - Revalidation*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

*Per 42 CFR § 424.515, Medicare providers and suppliers (other than DMEPOS suppliers) must resubmit and recertify the accuracy of their enrollment information every five years in order to maintain Medicare billing privileges. CMS will issue instructions on the revalidation process in the near future. Contractors shall not initiate revalidation until such instructions are issued.*

## *10 - Documentation*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

*To ensure that proper internal controls are maintained and that important information is recorded in case of potential litigation, the contractor shall maintain documentation as outlined in this section 10. CMS cannot stress enough how crucial it is for contractors to document their actions as carefully and thoroughly as possible.*

*Note that these requirements are in addition to, and not in lieu of, all other documentation or document maintenance requirements that CMS has mandated.*

### *A. Written and Telephonic Communications*

*(For purposes of this section 10, "written correspondence" includes faxes and e-mails.)*

*The contractor shall:*

- *Retain copies of all written correspondence pertaining to the provider, regardless of whether the correspondence was initiated by the contractor, the provider, CMS, State officials, etc.*

- *Document when it sends written letters and faxes to providers. For instance, if the carrier crafts an approval letter to the supplier dated March 1 but sends it out on March 3, the contractor shall note this in the file.*

- *Document all referrals to CMS, the PSC, or the OIG.*

- *Document any and all actual or attempted telephonic or face-to-face contacts with the provider, any representative thereof, or any other person regarding a provider. This includes, but is not limited to, the following situations:*

    - *Telephoning a provider about its application. (Even if the provider official was unavailable and a voice mail message was left, this must be documented.)*

    - *Requesting information from the State or another contractor concerning the applicant or enrollee;*

    - *Contacting the PSC for an update concerning an application sent to them;*

    - *Phone calls from the provider;*

    - *Conducting a meeting at the contractor's headquarters/offices with officials from a hospital concerning problems with its application;*

    - *Contacting CO or the RO's survey and certification staff – and receiving instructions therefrom - about a problem the contractor is having with an applicant or an existing provider;*

    - *Contacting the provider's billing department with a question about the provider.*

*When documenting oral communications, the contractor shall indicate: (1) the time and date of the call or contact; (2) who initiated contact; (3) who was spoken with; and (4) what the conversation pertained to. Concerning the last requirement, the contractor need not write down every word that was said during the conversation. Rather, the documentation should merely be adequate to reflect the contents of the conversation. The documentation can be stored electronically, if the contractor can provide access within 24 hours upon request.*

*Note that the documentation requirements in this subsection (A) only apply to enrolled providers and to providers that have already submitted an enrollment application. In other words, these documentation requirements go into effect only after the provider*

*submits an initial application. To illustrate, if a hospital contacts the contractor requesting information concerning how it should enroll in the Medicare program, this need not be documented because the hospital has not yet submitted an enrollment application.*

*If an application is returned per section 3.2 of this manual, the contractor shall document this. The manner of documentation lies within the contractor's discretion.*

***B. Verification of Data Elements***

*Once the contractor has completed its review of the CMS-855 (e.g., approved/denied application, approved change request), it shall provide a written statement asserting that it has: (1) verified all data elements on the application, and (2) reviewed all applicable names on the CMS-855 against Qualifier.net, the MED, and the GSA debarment list. The statement must be signed and dated. It can be drafted in any manner the contractor chooses so long as it certifies that the above-mentioned activities were completed. The record can be stored electronically.*

*For each person or entity that appeared on the MED or GSA lists, the contractor shall document the finding via a screen printout. In all other situations, the contractor is not encouraged to document their reviews via screen printouts. Simply using the verification statement described above is sufficient. Although the contractor has the discretion to use screen prints if it so chooses, the verification statement is still required.*

## *11 – Special Processing Situations*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

## *11.1 – Tie-In Notices*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

*This section only applies to fiscal intermediaries.*

***A. General Information***

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

- *Initial enrollment;*
- *CHOW;*
- *Acquisition/Merger;*
- *Consolidation;*
- *Addition or deletion of HHA branch, hospital unit, or OPT extension site;*

- *Voluntary and involuntary termination of billing numbers*

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

*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 that paperwork. (This applies to initial applications, CHOWs, practice location additions, etc.)*

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

***B. Payments During CHOWs***

*In a CHOW, the intermediary shall continue to pay the old owner until it receives the tie-in notice from the RO. Hence, any request from the old or new owner to change the EFT account to that of the new owner shall be denied. It is ultimately the responsibility of the old and new owners to work out any payment arrangements between them while the CHOW is being processed by the intermediary and the RO.*

## *11.2 – Out-of-State Practice Locations for Certified Providers*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

*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 fiscal intermediary 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 intermediary jurisdiction. If State Y requires that any entity performing services in Y must be surveyed or the RO says that the provider must sign a separate provider agreement and obtain a separate billing number for its State Y services, then 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 need to submit a CMS-855A change of information adding the out-of-state location.*

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

*In short, therefore, if a provider performs services in a State serviced by another intermediary, a new enrollment is required with that intermediary. If both States are in the same intermediary jurisdiction, a CMS-855 initial application or a CMS-855 change of information will be necessary; whether an initial or a change request is required will depend on State law and what the RO says. In either case, the intermediary must create a new enrollment record in PECOS – one for each State. (See section 7.2 of this manual for additional guidance.)*

## *11.3 – Provider-Based*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

*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 intermediary 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 wants to change 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 wants to enroll in Medicare and become provider-based to a hospital, it need not independently enroll with the carrier. The hospital can simply add the group as a practice location on its 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 should submit a CMS-855B to the carrier as an initial enrollment.*

- ***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 practice should submit a CMS-855B to the carrier to terminate its enrollment therewith.*

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

## *11.4 – State Survey Actions*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

*Information on the CMS-855 is still considered valid (even if outdated) if caused by a delay in the State agency survey. However, if the application is over 6 months old due to provider delays, the provider must update its CMS-855A application and sign a new certification statement. The contractor shall validate any updated information. If the applicant is an HHA, it must resubmit capitalization data as required by section 12 of the CMS-855A.*

## *11.5 – Carrier Processing of Hospital Applications*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

***A. Group Practices***

*The carrier shall review all CMS-855B applications for hospital-owned clinics/physician practices and department billings. The carrier 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 carrier shall process the application normally. If, however, the applicant will bill as provider-based, the carrier shall notify the applicant that the hospital must report any changed practice locations to the its intermediary via the CMS-855A.*

*For new hospital applications submitted to the carrier, the latter shall only issue the necessary billing numbers upon notification that a provider agreement has been issued. If a CHOW is involved, the carrier shall only issue the new numbers upon notification that the provider agreement has been transferred to the new owner. In both cases, the carrier shall note in the file when it completed all steps involved in processing the application other than receipt of the notice that the provider agreement has been issued/transferred.*

***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 carrier via the CMS-855B (e.g., as a hospital department, outpatient location, etc.).*

## *11.6 – Par Agreements*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

*Certain suppliers who provide Medicare services are required to accept assignment for their claims, meaning that they must accept the Medicare allowed charge amount as payment in full for their services. (The beneficiary's liability is limited to any applicable deductible plus the 20 percent coinsurance.) These suppliers include:*

- *Physician assistants;*
- *Nurse practitioners;*
- *Clinical nurse specialists;*
- *Clinical psychologists;*
- *Clinical social workers;*
- *CRNAs;*
- *Nurse midwives;*
- *Registered dietitians and nutrition professionals*

*(Physicians and PT/OTs in independent practice are not required to accept assignment.)*

*Suppliers that are required to accept assignment must complete and submit to the carrier a CMS 460 form (known as a "par agreement). The form must be signed by an authorized or delegated official – as those terms are defined in this manual - of the supplier if the latter is an organization. If the supplier is an individual, that person must sign the form. Suppliers that are not required to accept assignment may still choose to accept assignment by completing and submitting the CMS 460.*

## *11.7 – Opt-Out*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

*section 1802 of the Social Security Act, as amended by § 4507 of the BBA of 1997, permits a physician or practitioner to "opt out" of Medicare and enter into private contracts with Medicare beneficiaries if specific requirements are met. Note that 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 the application after the emergency services were provided.*

## *12 – Provider and Supplier Types/Services*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

## *12.1 – Community Mental Health Centers (CMHCs)*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

### *A. Initial CMHC Enrollment*

*The intermediary shall process the CMHC's CMS-855A as it would any other application. It shall also ensure that a completed and signed CMHC attestation statement from the State is received. If the CMHC does not submit one, the intermediary shall recommend denial. (The attestation requirement also applies to new owners in a CHOW.)*

*If the intermediary issues a recommendation for approval, it shall send a copy of the CMS-855A to the State agency (or, for intermediaries in RO 9, the intermediary's RO) with its recommendation. Using the "Community Mental Health Center Site Visit Request Form" below, the intermediary shall contact the appropriate RO to initiate a site visit of the CMHC applicant; a copy of the request should be sent to the State agency.*

*Once the site visit is completed, the RO will send the intermediary a tie-in notice to inform the latter of the outcome of the site visit and the effective date of Medicare participation, if applicable.*

*Note that a CMHC must list as practice locations on its CMS-855A all alternative sites where core services are provided (i.e., proposed alternative sites for initial applicants and actual alternative sites for those CMHCs already participating in Medicare). A CMHC must provide mental health services principally to individuals who reside in a defined geographic area (service area); that is, they must service a distinct and definable community. A CMHC that operates outside of this specific community must have a separate provider agreement/number and enrollment, and must individually meet the requirements to participate. CMS will determine if the alternative site is permissible or whether the site must have a separate agreement/number.*

### *B. Site Visits to Existing CMHCs*

*On occasion, the RO may wish to perform a site visit of an existing, enrolled CMHC. The intermediary shall furnish any and all background information requested by the RO. It*

*shall also request that the CMHC complete a full CMS-855A if one is not already on file. All inquiries and correspondence relating to the site visit shall be directed to the RO.*

### *C. Site Visit Request Form*

*COMMUNITY MENTAL HEALTH CENTER SITE VISIT REQUEST FORM*
*Date of Request: _____*
*Check Type of Site Visit:*
*Initial Applicant*
*Change of Ownership with Assignment*
*Change of Ownership without Assignment*
*Other - (explain reason for visit) _____*
*Please complete the following for the CMHC applicant requiring a site visit:*
*Name:*

*_____*
*Address:*

*_____*
*Phone Number: _____*
*Owner(s) Name:*

*_____*
*Managing/Directing Employee:*

*_____*
*Contact Person:*

*_____*
*Please complete the following for the FI:*
*Name:*

*_____*
*Address: _____*

*Phone Number: _____*
*Fax Number: _____*
*E-mail Address: _____*
*Contact Person:*

*_____*
*Corresponding CMS RO: _____*
*CMS RO Contact: _____*

### *D. Deactivation*

*The CMHCs are the only entity enrolling with a fiscal intermediary that is subject to deactivation for 12 consecutive months of non-billing. The fiscal intermediary shall follow the procedures outlined in section 7 of this manual regarding any CMHC that has not billed for 12 consecutive months. The intermediary shall notify the RO in writing about the deactivation. (See section 13.2 of this manual for more information on deactivations.)*

## *12.2 – Diabetes Self-Management Training (DSMT)*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

*Diabetes Education, or DSMT, is not a separately recognized provider type. It is merely an additional service that an existing provider or supplier can bill for. Hence, a provider that wishes to perform DSMT services need not submit a CMS-855B to the carrier. It need only submit an American Diabetes Association (ADA) certificate (or other CMS-recognized certification); the carrier, of course, shall ensure that the provider is already enrolled in Medicare before allowing the provider to bill for DSMT services. If the provider is not enrolled with the contractor (e.g., is a DMEPOS supplier only; is a supplier enrolled only with another carrier), it must complete a full CMS-855B.*

*Since DMERCs cannot pay DSMT claims, a DMEPOS supplier must separately enroll with its local Part B carrier, even if it has already completed a CMS-855S and is enrolled in Medicare. In order to file claims for diabetes education services, a DMEPOS supplier must also be certified by a CMS-approved national accreditation organization, or during the first 18 months after the effective date of the final rule, recognized by the ADA as meeting the national standards for DSMT as published in Diabetes Care, Volume 23, Number 5.*

*If a contractor receives an application from a DMEPOS supplier that would like to bill for DMST, it shall verify with the National Supplier Clearinghouse (NSC) that the applicant is currently enrolled and eligible to bill the Medicare program. If the applicant is indeed an approved supplier and is enrolled with the NSC, the contractor shall process the application normally.*

## *12.3 - Mass Immunizers Who Roster Bill*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

*If State law allows a pharmacist to immunize, the carrier may enroll the pharmacist as an individual. If the pharmacist does not have a practice location (since most of his/her services are provided at local malls, community centers, etc.), the carrier shall request the applicant to enter the address where his/her records are stored; the address cannot be a post office box.*

*Persons who enroll in Medicare as mass immunization/roster billers cannot bill for any services other than influenza and penumococcal pneumonia vaccines. The claims processing system must note that the applicant has filed to bill for influenza/PPV only. If the applicant is eligible to bill for other services, it must qualify and enroll as a different supplier/specialty type.*

*All mass immunizers and roster billers must agree to accept assignment of the influenza/penumococcus benefit as payment in full and cannot "balance bill" the beneficiary.*

## *12.4 – Enrolling Indian Health Service (IHS) Facilities as Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Suppliers*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

### *A. National Supplier Clearinghouse (NSC) Responsibilities*

*The NSC shall enroll IHS facilities as DMEPOS suppliers in accordance with the general enrollment procedures cited in chapter 10 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 Sec. 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).*

## *13 – Reserved for Future Use*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

## *14 – Model Correspondence Language*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

### *A. Rejection*

*"Dear Entity:*

*We received your enrollment application on _____. We sent to you a letter on _____ asking for (additional or clarifying) information. Unfortunately, you did*

*not respond (or only sent a portion of the requested information.) Therefore, we must reject your application. If, at a later date, you wish to enroll in Medicare, you will need to submit another CMS-855 enrollment application."*

***B. Returns***

*"Dear Entity:*

*We received your enrollment application on _____. Unfortunately, we are returning your application because _____. If, at a later date, you wish to enroll in Medicare, you will need to submit another CMS-855 enrollment application."*

***C. Denials***

*"Dear Supplier:*

*We received your enrollment application on _____. Unfortunately, your request to participate in the Medicare program is denied. After careful review of your application, it was determined that you do not meet the conditions of enrollment or meet the requirement to qualify as a health care supplier because _____.*

*You may, of course, take steps to correct the deficiencies and reapply to establish your eligibility. (Insert standard appeals language.)*

***D. Redeterminations and Appeals***

*In its acknowledgment letter, the contractor shall advise the requesting party that the redetermination or hearing will be conducted and a determination issued as soon as possible. The contractor shall include a copy of its acknowledgment letter in the redetermination/appeal file.*

*A model acknowledgment letter is contained below. The language therein may need to be modified, depending upon: (1) whether it is the contractor or the hearing officer (HO) assigned to the case that is sending out the acknowledgment, and (2) any special circumstances involved in the case. In addition, if a hearing is requested (as opposed to a redetermination), the contractor or HO shall adhere to the following:*

- *If the type of hearing desired is not specified in the request, the contractor shall advise the appellant of his/her/its right to participate in an in-person or telephone hearing if one is requested. The contractor shall inform the applicant that he/she/it must contact it within 21 days of the date of the letter if the latter would like to participate in the hearing (The contractor has the discretion to alter this timeframe as it deems fit, so long as the new timeframe is reasonable). If the applicant gives such notice in a timely manner, the contractor shall send a follow-up letter to the applicant identifying the scheduled date and time of the hearing.*

- *If the appellant initially requested an on-the-record or in-person hearing, the contractor shall simply send a copy of the acknowledgement letter to the applicant containing the date and time of the hearing.*

*MODEL ACKNOWLEDGMENT LETTER FORMATION*

*CMS alpha representation*
*PART B CARRIER*
*Or*
*PART B DMERC (A/B/C/D)*
*Appeals Phone Number*

*ACKNOWLEDGMENT OF REQUEST FOR PART B HEARING OFFICER HEARING [On a copy of the acknowledgement letter addressed to other parties, include a statement indicating that this is a copy of the acknowledgment of a request for a Part B Hearing Officer Hearing]*

*Date:*

*Appellant's Name*

*Appellant's Address*

*RE:*

*Application for (identify type of application submitted, supplier type, etc.)*

*Dear Name of Appellant:*

*Your request for a (identify type of request (e.g., HO hearing, redetermination)) was received on [date that hearing request was received in the corporate mailroom].*

*(IF A HEARING WAS REQUESTED, use either of the following:*

*A Hearing Officer will be assigned to this case who will make a new and independent decision based on the evidence in the case file and on any additional evidence that you would like to submit. [OR]*

*I am the Hearing Officer assigned to this case, and I will make a new and independent decision based on the evidence in the case file and on any additional evidence that you would like to submit.)*

*[If the appellant wishes to participate by phone or in-person, identify the scheduled date and time of the hearing. If the appellant did not specify its desire to participate, advise the appellant of his/her/its right to participate in an in-person or telephone hearing. The appellant must inform the contractor of his/her/its desire to participate within 21 days of the date of the letter.]*

*If you need more information or have any questions, feel free to contact (appropriate name) at (phone number).*

*Sincerely,*

*(Name of Individual)*
*(Title)*
*Cc:*
*Medicare Government Services*
*I Jones Street*
*(City), (State) (Zip)*

*A CMS CONTRACTED CARRIER*

# *15 – PECOS*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

## *A. General Information*

*The PECOS captures all enrollment information contained on the CMS-855, identifies relationships between Medicare providers, tracks each enrollment application, performs inquiries, and produces reports. It monitors each enrollment application from the time the enrollment form is received until the contractor finishes processing it. PECOS will also be used to update enrollment information and to communicate with the claims processing system.*

## *B. Timeframes*

*As stated in section 2.3 of this manual, the contractor shall create an L & T and – if applicable – an enrollment record in PECOS within 15 calendar days of receipt of the application in the mailroom. This applies to initial applications, changes of information, CHOWs submitted by old and new owners, reassignments, etc. (It does not apply to applications that are returned under sections 3.2 of this manual.)*

*For all applications that fall within the "Changes of Information" category in section 2.2 of this manual, the contractor shall update the provider's enrollment record in PECOS prior to its completion of the processing of the application. The exceptions to this are:*

- *The application is denied (or a recommendation for denial is made). The update need not be made, and the PECOS status should simply be changed to reflect the denial.*

- *The provider has no enrollment record in PECOS. If the contractor cannot obtain a full CMS-855 from the provider, the contractor need not create an enrollment record. It shall simply create an L & T record as normal.*

## *C. Skeletal Records*

*Contractors shall no longer create skeletal records (as that term is defined in CMS Change Request 2296, dated August 21, 2002) in PECOS under any circumstances. Enrollment records shall only be created when an entire CMS-855 is submitted.*

## *D. Non-CMS-855 Forms*

*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 manual, 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.*

***E. Communications with Other Contractors***

*When an intermediary or carrier asks another contractor (as the PECOS "record holder") to make a change to a particular associate profile, the record holder shall make the change within seven calendar days of the request. The record holder is free to ask the requestor to fax to it a copy of the applicable CMS-855 page containing the updated information; the PECOS record holder has the right to ensure that whatever data it enters into PECOS has been verified. However, the contractor should not be overly obstructionist on the matter. If the contractor feels uncomfortable about making the change, it shall contact its CO DPSE contractor liaison for guidance.*

*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 intermediary 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 intermediary or carrier sent/faxed to the contractor. For instance, suppose Provider X is enrolled in two different intermediary 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."*

***F. Special PECOS Rules***

*In addition to the PECOS instructions outlined in this section 15 and throughout this manual, the contractor shall abide by the following:*

- ***Multiple States in the Same Contractor Jurisdiction –*** *If a provider wishes to enroll in several States within the same contractor jurisdiction, the contractor must create a separate enrollment record for each State – even if the provider only needed to submit a single CMS-855 form encompassing all the States.*

- ***Adding an Individual to an Existing Group***

  - *If a CMS-855B is not on file for the group, the latter shall submit a full CMS-855B, along with the CMS-855R. The CMS-855B shall be processed like an initial enrollment application, thus requiring the creation of a new enrollment record. The CMS-855R should not be processed until the group's enrollment record has been put in "approved" status.*

  - *If a CMS-855I is not on file for the individual, the person shall submit a full CMS-855I, along with the CMS-855R. The CMS-855I shall be processed like an initial enrollment application, thus requiring the creation of a new enrollment record. The CMS-855R should not be processed until the person's enrollment record has been put in "approved" status.*

  - *For a CMS-855R received for an individual already enrolled with Medicare but who is not in PECOS, the person shall submit a full CMS-855I, along with the CMS-855R. The CMS-855I shall be processed like an initial enrollment application, thus requiring the creation of a new enrollment record. The CMS-855R should not be processed until the person's enrollment record has been put in "approved" status.*

## *16 – External Reporting Requirements*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

### *A. Fiscal Intermediary Reporting Requirements*

*To help facilitate CMS's role in monitoring intermediaries' ongoing performances in processing CMS-855A enrollment applications, intermediaries shall report to CMS on a quarterly basis information regarding: (1) the number of incoming CMS-855A applications, and (2) the timeframes in which these applications were processed.*

*To ensure consistency in data collection efforts, fiscal intermediaries shall submit this information to CMS via the "FI Enrollment Workload Spreadsheet" (identified in Change Request 4213). As evidenced by the spreadsheet, the primary workload categories are as follows:*

- *Initial CMS-855A applications (i.e., those that are not part of a change of ownership (CHOW), acquisition/merger or consolidation);*

- *CHOW submissions for "new" owners (this includes acquisition/merger and consolidation applications submitted by new owners);*

- *CHOW submissions for "old" owners (this includes acquisition/merger and consolidation applications submitted by old owners);*

- *Changes of Information; and*

- *Entire CMS-855A applications submitted by enrolled providers that have never completed a CMS-855A application before. (This most commonly happens in two instances: (1) the provider is undergoing an EFT change, or (2) the provider is submitting a non-EFT change of information and agrees to submit an entire application.) For purposes of this reporting requirement, these applications will be referred to as "Full CMS-855A Applications."*

*The number of applications that fall within each of the aforementioned categories are further subcategorized as follows:*

- *Incoming for the previous quarter;*

- *Applications processed to completion during the previous quarter. (This is further broken down by applicable timeframes.) This does not mean that the entire application had to be processed – from beginning to end – in the prior quarter. Rather, the intermediary simply completed processing that application in the previous quarter, regardless of when it first received the application in its mailroom.*

- *Applications pending at the end of the previous quarter. (This is further broken down by applicable timeframes.)*

*Those boxes on the spreadsheet that are shaded in gray and marked "N/A" need not be completed.*

*Once PECOS is able to produce reports to the satisfaction of CMS, intermediaries will no longer be required to manually provide this information.*

***B. Carrier Reporting Requirements***

*To help facilitate CMS's role in monitoring carriers' ongoing performances in processing CMS-855 enrollment applications, carriers shall report to CMS on a quarterly basis information regarding: (1) the number of incoming CMS-855 applications, and (2) the timeframes in which these applications were processed.*

*To ensure consistency in data collection efforts, carriers shall submit this information to CMS via the "Carrier Enrollment Workload Spreadsheet" (identified in Change Request 4213). As evidenced by the spreadsheet, the primary workload categories are as follows:*

- *Initial Applications – These include the following:*

  - *A new receipt of either a CMS-855I or CMS-855B*

  - *A CMS-855R that is received with an initial CMS-855I or CMS-855B. Because timeliness requirements allow carriers to process a CMS-855R within 60 days when it accompanies an initial CMS-855B or CMS-855I, carriers shall count the CMS-855R as an initial application. However, the CMS-855R shall not be recounted in the CMS-855R column.*

  - *A CMS-855I or CMS-855B that is in PECOS, yet the supplier is enrolled by another carrier. In situations where a supplier enters into a different carrier's jurisdiction and the new carrier has to update the information, count this as an initial enrollment.*

- *Reassignments – These include the following:*

  - *A CMS-855R that does not accompany an initial CMS-855I or CMS-855B.*

- *Changes of Information*

*The number of applications that fall within each of the aforementioned categories are further subcategorized as follows:*

- *Incoming for the previous month;*

  - *Applications processed to completion during the previous month. (This is further broken down by applicable timeframes.) This does not mean that the entire application had to be processed – from beginning to end – in the prior month. Rather, the carrier simply completed processing that application in the previous month, regardless of when it first received the application in its mailroom.*

  - *Applications pending at the end of the previous month. (This is further broken down by applicable timeframes.)*

*Those boxes on the spreadsheet that are shaded in gray and marked "N/A" need not be completed. Once PECOS is able to produce reports to the satisfaction of CMS, carriers will no longer be required to manually provide this information. (This worksheet replaces the old "Workload Report" and "Aging Report" that carriers had previously been using.)*

### *C. Carrier Counting of Applications*

*In terms of "counting" applications, carriers should get one "count" for each application they process regardless of: (1) the type of application involved (e.g., CMS-855I, CMS-855R), (2) whether the forms arrived in a single package, or (3) whether the application in question was rejected due to the provider's non-responsiveness. For instance, suppose a group practice is enrolling for the first time. It employs five doctors, all of whom will be reassigning their benefits*

*to the group. The group thus submits in a single package one CMS-855B, five CMS-855Is, and five CMS-855Rs. The carrier should count this as 11 incoming applications.*

## *17 – Maintenance and Release of CMS-855 Data*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

## *17.1 – Security*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

*The contractor shall ensure that the highest level of security is maintained for all systems and its physical and operational processes, in accordance with the CMS/Business Partners Systems Security Manual (BPSSM) and the Program Integrity Manual.*

*Applications shall never be removed from the controlled area to be worked on at home or in a non-secure location. Additionally, provider enrollment staff must control and monitor all applications accessed by other contractor personnel.*

*All contractor staff shall be trained on security procedures as well as relevant aspects of the Privacy Act and the Freedom of Information Act. This applies to all management, users, system owners/managers, system maintainers, system developers, operators and administrators, including contractors and third parties, of CMS information systems, facilities, communication networks and information.*

*Note that these instructions are in addition to, and not in lieu of, all other instructions issued by CMS regarding security.*

## *17.2 - Release of Information*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

*Once the provider has submitted an enrollment application (as well as after it has been enrolled), the contractor may not release – either orally or in writing - any information about the provider's enrollment status (unless specifically authorized in some other CMS instruction) to any person in the provider's organization other than an authorized or delegated official of the provider, or the provider's contact person listed in section 13 of the CMS-855. It is recommended that the contractor notify the provider of this as early in the enrollment process as possible to avoid later problems.*

*In addition:*

- *When sending e-mails, the contractor shall not transmit sensitive data, such as SSNs or EINs.*

- *The contractor may not send PECOS screen printouts to the provider.*

- *If the provider requests a copy of the CMS-855 it has on file, the contractor shall ask an authorized or delegated official on file to submit a signed letter on the provider's letterhead formally requesting the CMS-855. If he/she sends it in and the contractor has no reason to question its authenticity, it may furnish the provider one copy of its CMS-855.*

- *Carriers shall not send Medicare provider numbers (PINs) to groups or organizations, including the group's authorized or delegated official. If a group/organization needs to know the PIN number of an individual provider, it must contact the provider directly for this information or have the individual provider request this information in writing from the carrier. If the individual provider requests its PIN number, the carrier can mail it to the provider's practice location. The contractor should never give this information over the phone.*

## *17.3 – File Maintenance*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

*Contractors shall maintain and store all documents relating to the enrollment of a provider into the Medicare program. These documents include, but are not limited to, Medicare enrollment applications and all supporting documents, attachments, correspondence, and appeals submitted in conjunction with an initial enrollment, reassignment, change of enrollment, revalidation, etc.*

*Supporting documentation includes, but is not limited to:*

- *Copies of Federal, State and/or local (city/county) professional licenses, certifications and/or registrations;*

- *Copies of Federal, State, and/or local (city/county) business licenses, certifications and/or registrations;*

- *Copies of professional school degrees or certificates or evidence of qualifying course work;*

- *Copies of CLIA certificates and FDA mammography certificates;*

*Medicare contractors shall dispose of the aforementioned records as described below:*

*1) Provider/Supplier and Durable Medical Equipment Supplier Application*

*a. Rejected applications as a result of provider failing to provide additional information*

*Disposition: Destroy when 7 years old.*

*b. Approved applications of provider/supplier*

*Disposition: Destroy 15 years after the provider/supplier's enrollment has ended.*

*c. Denied applications of provider/supplier.*

*Disposition: Destroy 15 years after the date of denial.*

*d. Approved application of provider/supplier, but the billing number was subsequently revoked*

*Disposition: Destroy 15 years after the billing number is revoked.*

*e. Voluntary deactivation of billing number*

*Disposition: Destroy 15 years after deactivation.*

*f. Provider/Supplier dies*

*Disposition: Destroy 7 years after date of death.*

*2) Electronic Mail and Word Processing System Copies*

*a) Copies that have no further administrative value after the recordkeeping copy is made. These include copies maintained by individuals in personal files, personal electronic mail directories, or other personal directories on hard disk or network drives, and copies on shared network drives that are used only to produce the recordkeeping copy.*

*Disposition: Delete within 180 days after the recordkeeping copy has been produced.*

*b) Copies used for dissemination, revision or updating that are maintained in addition to the recordkeeping copy*

*Disposition: Delete when dissemination, revision, or updating is complete.*

## *18 – Customer Service*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

## *18.1 - Web Sites*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

*Contractors must provide a link to CMS' provider/supplier enrollment Web site located at http: www.cms.hhs.gov/MedicareProviderSupEnroll. The link shall be available on the contractor's existing provider outreach Web site (which should be an established subdomain of the contractor's current commercial Web site) and it must comply with the guidelines stated in the Provider/Supplier Information and Education Web site section (Activity Code 14101) under the Provider Communications (PCOM) Budget and Performance Requirements (BPRs). Bulletins, newsletters, seminars/workshops and other information concerning provider enrollment issues shall also be made available on the existing provider outreach Web site. All contractor Web sites must comply with section 508 of the Rehabilitation Act of 1973 in accordance with, 36 CFR §1194, and must comply with CMS' Contractor Web site Standards and Guidelines posted on CMS's Web site.*

*The CMS Provider/Supplier Enrollment Web site, http://www.cms.hhs.gov/ MedicareProviderSupEnroll, furnishes the user with access to provider/supplier enrollment forms, specific requirements for provider/supplier types, manual instructions, frequently asked questions (FAQs), contact information, hot topics, and other pertinent provider/supplier information. The contractor shall not duplicate content already provided at the CMS provider/supplier enrollment Web site, and shall not reproduce the forms or establish the contractor's own links to forms. It shall, however, have a link on its Web site that goes directly to the forms section of the CMS provider/supplier enrollment site.*

*On a quarterly basis, each contractor shall review and provide updates regarding their information that we show at URL: http://www.cms.hhs.gov/MedicareProviderSupEnroll/PSEC. If the contractor services several States with a universal address and telephone number, the contractor shall report that information. In situations where no actions are required, a response from the contractor is still required (i.e., the contact information is accurate). In addition, only information that pertains to provider enrollment activity for the contractor's jurisdiction is to be reported. All updates shall be sent directly via e-mail to the DPSE Policy Mailbox.*

## *18.2 - Provider Enrollment Inquiries*

***(Rev.150, Issued: 06-30-06, Effective: 07-03-06, Implementation: 07-03-06)***

*The contractor's customer service unit may handle provider enrollment inquiries that do not involve complex enrollment issues. Examples of inquiries that can be processed by customer service units include:*

- *Application status checks (e.g., "Has the contractor finished processing my application?");*

- *Furnishing information on where to access the CMS-855 forms (and other general enrollment information) on-line;*

- *Explaining to providers/suppliers which CMS-855 forms should be completed.*