CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 260	Date: June 20, 2008
	Change Request 6065

SUBJECT: Clarification of Chapter 10

I. SUMMARY OF CHANGES: This change request updates various provisions in Pub. 100-08, chapter 10 (hereinafter referred to as "chapter 10").

NEW / REVISED MATERIAL
EFFECTIVE DATE: July 22, 2008
IMPLEMENTATION DATE: July 22, 2008

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

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	10/Table of Contents
R	10/4.2.5/Section 2 of the CMS-855A
R	10/4.4/Practice Location Information
R	10/4.8/Billing Agencies
R	10/6.2/Denials
R	10/6.2.1/Suppliers Not Eligible to Participate
R	10/7.2/Special Instructions for Certified Providers, ASCs, and Portable X-ray Suppliers
R	10/8/Electronic Funds Transfers (EFT)
R	10/11.4/Non-Participating Emergency Hospitals, Veterans Administration (VA) Hospitals, and Department of Defense (DOD) Hospitals
N	10/11.9/Carrier Assignment of Provider Transaction Access Numbers (PTANs)
R	10/13.1/CMS or Contractor Issued Deactivations
R	10/13.2.1/Revocations Involving Certified Suppliers and Providers

III. FUNDING:

SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

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

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

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

Attachment - Business Requirements

Pub. 100-08	Transmittal: 260	Date: June 20, 2008	Change Request: 6065

SUBJECT: Clarification of Chapter 10

Effective Date: July 22, 2008

Implementation Date: July 22, 2008

I. GENERAL INFORMATION

A. Background: This change request updates various provisions in Pub. 100-08, chapter 10 (hereinafter referred to as "chapter 10").

B. Policy: The purpose of this change request is to address certain provider enrollment topics that have recently arisen.

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6065.1	The contractor shall forward a copy of the Deactivation Summary Report provided by the multi-carrier system (MCS) to its designated DPSE contractor liaison no later than the last calendar day of each month.	X			X						
6065.2	In entering the change request into PECOS, the contractor shall use the date it received the change request in its mailroom as the actual receipt date in PECOS; the date the tie-in notice was issued shall not be used.	X		X	X	X					
6065.2.1	With respect to business requirement 6065.2, the contractor shall explain the reason for the discrepancy between the receipt date and the tie-in date in the "Comments" section in PECOS and in the provider file.	X		X	X	X					
6065.3	The contractor shall note that if the applicant is a certified provider or certified supplier and one of the denial reasons listed in section 6.2, of chapter 10, is implicated, the contractor need not submit a	X		X	X	X					

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	recommendation for denial to the State/RO.										
6065.4	For suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS), the DME MAC, not the national supplier clearinghouse (NSC), is responsible for obtaining, updating and processing CMS-588 changes of information.		X								
6065.5	The contractor shall note that a Department of Defense (DOD) hospital must complete and submit a CMS-855A enrollment application and CMS-588 EFT form in order to bill Medicare for any services performed.	X		X							
6065.6	The contractor shall note that per section 11.9, of chapter 10, a hospital that requests an additional Part B PTAN must associate the new PTAN with an NPI in section 4 of the CMS-855B.	X			X						

III. PROVIDER EDUCATION TABLE

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

IV. SUPPORTING INFORMATION

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

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

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

VI. FUNDING

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

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

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

Medicare Program Integrity Manual
Chapter 10 - *Medicare* Provider/Supplier Enrollment

Table of Contents
(Rev.260, 06-20-08)

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

11.9 – Carrier Assignment of Provider Transaction Access Numbers (PTANs)

4.2.5 – Section 2 of the CMS-855A

(Rev.260, Issued: 06-20-08, Effective: 07-22-08, Implementation: 07-22-08)

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

As explained in section 12.1.6, a branch is a location or site from which an HHA provides services within a portion of the total geographic area served by the parent agency. The branch is part of the HHA and is located sufficiently close to the parent agency such that it shares administration, supervision, and services with the parent. If an existing HHA wishes to add a branch, it is considered a change of information on the CMS-855A. An HHA subunit, meanwhile, is a semi-autonomous organization under the same governing body as the parent HHA and serves patients in a geographic area different from that of the parent. Because of its distance from the subunit, the parent is incapable of sharing administration, supervision and services with the subunit on a daily basis. If the HHA wants to add an HHA subunit, it must complete an initial enrollment application for the subunit. (The subunit also signs a separate provider agreement.)

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

When the provider seeks to add an HHA branch or a hospital unit, the contractor shall make a recommendation for approval or denial and forward the package to the State as described in section 7.2 of this manual. However, the contractor shall emphasize to the provider that a recommendation of approval of the addition of the branch or unit does not signify CMS's approval of the new location. Only the RO can approve the addition.

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

B. Critical Access Hospitals

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

C. Transplant Centers

For purposes of Medicare enrollment, a hospital transplant center is treated similarly to a hospital sub-unit. If the hospital wishes to add a transplant center, it must check the "other" box in section 2A2 of the CMS-855A, write "transplant center" on the space provided, and follow the standard instructions for adding a sub-unit. *Unless CMS*

indicates otherwise, the contractor shall process the application in the same manner it would the addition of a hospital sub-unit; however, no separate enrollment in PECOS need be created for the transplant center.

4.4 – Practice Location Information

(Rev.260, Issued: 06-20-08, Effective: 07-22-08, Implementation: 07-22-08)

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

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

A. Practice Location Verification

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

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

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

In addition:

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

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

B. Do Not Forward (DNF)

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

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

C. Remittance Notices/Special Payments

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

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

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

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

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

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

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

- One of the provider's practice locations

- A P.O. Box

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

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

- Correspondence address

4.8 – Billing Agencies

(Rev.260, Issued: 06-20-08, Effective: 07-22-08, Implementation: 07-22-08)

(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. 100-04, chapter 1, section 30.2. The only exception to this is if the contractor discovers that the "special payments" address in section 4 of the provider's 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 TIN 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.)

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

6.2 – Denials

(Rev.260, Issued: 06-20-08, Effective: 07-22-08, Implementation: 07-22-08)

A. Denial Reasons

Per 42 CFR §424.530(a), *contractors* must deny an enrollment application if any of the situations described below are present*, and must* provide appeal rights.

When issuing a denial, the contractor shall insert the appropriate regulatory basis (e.g., 42 CFR §424.530(a)(1)) into its determination letter. The contractor shall not use provisions from this chapter 10 as the basis for *denial.*

Note that if the applicant is a certified provider or certified supplier and one of the denial reasons listed below is implicated, the contractor need not submit a recommendation for denial to the State/RO. The contractor can simply: (1) deny the application, (2) close out the PECOS record, and (3) send a denial letter to the provider in a format similar to that which is used for carrier denials of non-certified supplier applications (see sections 14 and 19 of this manual). The contractor shall copy the State and the RO on said letter.

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

The provider or supplier is determined not to be in compliance with the Medicare enrollment requirements described in this section or on the enrollment application applicable to 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 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 §424.530(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 outlined in section 1128 of the Social Security Act.

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

The provider or supplier submitted false or misleading information on the enrollment application to gain 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, but is not limited to, 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 its denial letter, the contractor shall cite the appropriate statute and/or regulations containing the licensure/certification/authorization requirements for that provider or supplier type. For a listing of said statutes and regulations, refer to section 12 et seq. of this manual. Note that the contractor must identify in the denial letter the exact provision within said statute/regulation that the provider/supplier has failed to comply with.)

- 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 its denial letter, the contractor shall cite the appropriate statutory and/or regulatory citations containing the licensure/certification/authorization requirements for that provider or supplier type. For a listing of said statutes and regulations, refer to section 12

et seq. of this manual. Note that the contractor must identify in the denial letter the exact provision within said statute/regulation that the provider/supplier is not in compliance with.)

- The applicant does not qualify as a provider of services or a 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 provisions in §1842(b)(6) of the Act (42 U.S.C. 1395u(b)).

NOTE: This denial provision should be used in cases where the applicant is not recognized by any Federal statute as a Medicare provider or supplier (e.g., marriage counselors))

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

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

B. Denial Letters

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.

As previously indicated, 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 denial reasons. All applicable statutes and regulations, as well as a detailed factual rationale for the contractor's decision, must be identified in the letter. 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, the regulation in question, etc. If there were multiple reasons for denial, the letter shall state as such and shall furnish all of the aforementioned statutes, regulations, facts, etc. applicable to each reason. For more detailed information on the appropriate composition of denial letters, see section 19 of this manual.

C. Post-Denial Submission of Enrollment Application

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.

D. 30-Day Effective Date of Denial

A denial is effective 30 calendar days after the contractor sends its denial notice to the provider.

As stated in 42 CFR §424.530(c), 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.

See section 19 of this manual for information on Corrective Active Plans (CAP).

6.2.1 - Suppliers Not Eligible to Participate

(Rev.260, Issued: 06-20-08, Effective: 07-22-08, Implementation: 07-22-08)

The following is a list of suppliers who frequently attempt to enroll in Medicare but are not eligible to do so; no statute permits them to bill Medicare. Note that this list is not exhaustive.

If the contractor receives an enrollment application with one of the following types listed thereon, the contractor shall deny the application without development.

- Acupuncturist
- Assisted Living Facilities
- Birthing Centers
- Certified Alcohol and Drug Counselor
- Certified Social Worker
- Drug and Alcohol Rehabilitation Counselor
- Hearing Aid Center/Dealer
- Licensed Alcoholic and Drug Counselor
- Licensed Massage Therapist (LMT)
- Licensed Practical Nurse (LPN)
- Licensed Professional Counselor
- Marriage Family Therapist (MFT)
- Masters of Social Work
- Mental Health Counselor
- National Certified Counselor
- *Occupational Therapist Assistant*
- *Physical Therapist Assistant*
- Registered Nurse
- Speech and Hearing Center
- Speech Language Pathologist
- Substance Abuse Facility

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

(Rev.260, Issued: 06-20-08, Effective: 07-22-08, Implementation: 07-22-08)

Unless otherwise stated, the instructions in this section 7.2 apply only to certified providers, ASCs, and PXRSs.

A. RO Approval Needed

Certain change of information requests require: (1) a recommendation for approval/denial, (2) referral to the State/RO, and/or (3) a tie-in 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 require a recommendation and referral to the State/RO (unless the RO specifies otherwise). Note that this list is not necessarily exhaustive:

- The addition of a practice location or subunit, regardless of whether a tie-in or tie-out notice would normally be issued.

- Any change in the address of an existing practice location or subunit.

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

- Large-scale stock transfer.

- A change in the provider's legal business name or TIN that does not involve a CHOW.

For those transactions that generally 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 and need not send a concomitant notification to the State/RO. However, since each RO may have different preferences as to the changes it wishes to review/approve, the contractor is strongly advised to contact the applicable RO(s) to confirm: (1) those change requests that should be referred to the RO, and (2) whether the RO will issue a formal approval notice for said changes. This will also dictate when the PECOS status can be flipped to "approved." If, for instance, the contractor verifies 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. In cases where a tie-in or RO approval is required, the contractor shall not switch the record's status to "approved" until such approval has been received from the RO; so as not to keep the

record in "approval recommended" status interminably, if the contractor does not receive notification of approval from the RO after an excessive amount of time, it may contact the RO to see if said 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/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 merely submits a change of EFT information, this can be approved without a referral. If the provider is adding a practice location, however, the contractor should make a recommendation and referral to the State. (The contractor should forward the whole application to the State with a note explaining that the only matter the State needs to consider is the practice location addition.)

B. Deletion of Practice Location or Subunit

If the contractor receives a CMS-855 change request that deletes a practice location or subunit, it may terminate the location/unit without making a recommendation to the State and RO. No later than 3 business days after the contractor has finished processing the deletion, however, it shall notify the State and RO thereof; said notification can be made via letter, e-mail, or fax.

C. 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.

D. Post-Recommendation Changes

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

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

E. Hospital Addition of Practice Location

In situations where a 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.

8 – Electronic Fund Transfers (EFT)

(Rev.260, Issued: 06-20-08, Effective: 07-22-08, Implementation: 07-22-08)

If a provider does not have an established enrollment record in PECOS and wants to change any of its EFT information (e.g., bank routing number), it must submit a complete CMS-855 form before the contractor can effectuate the change. It is immaterial whether: (1) the provider or the bank (e.g., change in bank name via merger) was responsible for triggering the changed data or (2) the signer of the CMS-588 already has a signature on file with the contractor. (For more information on how the contractor should handle this type of situation, see sections 7.1.1 and 7.1.2 of this manual.)

In addition:

- **EFT Requirement** - All providers (including Federal, State and local governments) entering the Medicare program for the first time must use EFT in order to receive payments. Moreover, any provider not currently on EFT that submits any change to its existing enrollment data must also submit a CMS-588 form and thereafter receive payments via EFT. If the provider's bank of choice does not or will not participate in the provider's proposed EFT transaction, the provider must select another financial institution.

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

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

- **Sent to the Wrong Unit** - If a provider submits an EFT change request to the contractor but not to the latter's enrollment unit, the recipient unit shall forward it to the enrollment staff, which shall then process the change. The enrollment unit is ultimately responsible for processing EFT changes. As such, while it may send the original EFT form back to the recipient unit, the enrollment unit shall keep a copy of the EFT form and append it to the provider's CMS-855 in the file.

- **CMS 588 Changes and PECOS –** In situations where the only data the provider is changing is on the CMS-588 (i.e., no data is changing on the CMS-855), the contractor shall process the EFT change using the timeframes cited in section 2.2 of this manual; moreover, and notwithstanding any instruction to the contrary in this manual, the contractor shall create an L & T record using the "Other" button in PECOS.

- **Comparing Signatures** - If the contractor receives an EFT change request, it shall compare the signature thereon with the same official's signature on file to ensure that it is indeed the same person. (See also Pub. 100-04, chapter 24, section 40.7) If the person's signature is not already on file, the contractor shall

request that he/she complete section 6 of the CMS-855 and furnish his/her signature in section 15 or 16 of the CMS-855. (This shall be treated as part of the EFT change request for purposes of timeliness and reporting.)

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

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

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

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

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

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

(Rev.260, Issued: 06-20-08, Effective: 07-22-08, Implementation: 07-22-08)

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

11.9 – Carrier Assignment of Provider Transaction Access Numbers (PTANs)

(Rev.260, Issued: 06-20-08, Effective: 07-22-08, Implementation: 07-22-08)

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

13.1 – CMS or Contractor Issued Deactivations

(Rev.260, Issued: 06-20-08, Effective: 07-22-08, Implementation: 07-22-08)

A. General Instructions

The contractor may deactivate a provider or supplier's Medicare billing privileges when:

- A provider or supplier does not submit any Medicare claims for 12 consecutive calendar months. The 12 month period begins on the 1st day of the 1st month without a claims submission through the last day of the 12th month without a submitted claim;

- A provider or supplier fails to report a change to the information supplied on the enrollment application within 90 calendar days of when the change occurred. Changes that must be reported include, but are not limited to, a change in practice location, a change of any managing employee, and a change in billing services; or

- A provider or supplier fails to report a change in ownership or control within 30 calendar days.

The deactivation of Medicare billing privileges does not affect a supplier's participation agreement (CMS-460).

Providers and suppliers deactivated for non-submission of a claim are required to complete and submit a Medicare enrollment application to recertify that the enrollment information currently on file with Medicare is correct and must furnish any missing information as appropriate. The provider or supplier must meet all current Medicare requirements in place at the time of reactivation, and be prepared to submit a valid Medicare claim.

Providers and suppliers that fail to promptly notify the contractor of a change (as described above) must submit a complete Medicare enrollment application to reactivate their Medicare billing privileges or, when deemed appropriate, recertify that the enrollment information currently on file with Medicare is correct. Reactivation of Medicare billing privileges does not require a new State survey or the establishment of a new provider agreement or participation agreement.

Each contractor shall forward a copy of the Deactivation Summary Report provided by the Multi-Carrier System (MCS) to its designated DPSE contractor liaison *no later than the last calendar day of each month.*

B. DMEPOS Deactivation

The NSC shall require a DMEPOS supplier whose billing privileges are deactivated for non-submission of claims (see CFR 42 CFR 424.540) to submit a new Medicare enrollment application and meet all applicable enrollment criteria, including a site visit,

and accreditation when applicable, before an applicant can be approved. The NSC may not establish a retrospective billing date for a DMEPOS supplier whose billing privileges were deactivated due to claims inactivity.

13.2.1 - Revocations Involving Certified Suppliers and Providers

(Rev.260, Issued: 06-20-08, Effective: 07-22-08, Implementation: 07-22-08)

If the contractor determines that one or more of the revocation reasons identified in section 13.2 of this manual are applicable, the contractor may revoke the billing privileges of a certified provider or certified supplier without making a recommendation for approval or denial to the State and RO. It can, in other words, revoke billing privileges at the contractor level. However, as indicated in section 13.2, the contractor shall first notify DPSE prior to initiating any revocation action.

In revoking the provider or supplier, the contractor shall:

- Issue the revocation letter in accordance with section 13.2; *the contractor shall copy the RO and/or the State* on said *letter;*

- *After* determining the effective date of the revocation, end-date the entity's enrollment record in PECOS in the same manner as it would upon receipt of a tie-out notice from the RO.

- Afford the appropriate appeal rights per section 19 of this manual.