CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-08 Medicare Program Integrity	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 433	**Date: September 7, 2012**
	Change Request 8020

SUBJECT: Review of Debarment List and Processing of Tie-in Notices

I. SUMMARY OF CHANGES: The purpose of this change request (CR) is to focus: (1) the contractors' review of the General Services Administration Excluded Parties List System (EPLS) as part of the provider enrollment verification process, and (2) the timeframe for processing tie-in notices and/or approval letters from CMS' regional offices (ROs).

EFFECTIVE DATE: October 9, 2012
IMPLEMENTATION DATE: October 9, 2012

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

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	15/15.5.3/Final Adverse Actions
R	15/15.7.7.2.1/Processing Tie-In Notices/Approval Letters
R	15/15.7.8.3.1/Processing Tie-In Notices/Approval Letters

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

For Medicare Administrative Contractors (MACs):
The Medicare Administrative contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC statement of Work. The contractor is not obliged 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 Instructions

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

Attachment - Business Requirements

Pub. 100-08	Transmittal: 433	Date: September 7, 2012	Change Request: 8020

SUBJECT: Review of Debarment List and Processing of Tie-in Notices

EFFECTIVE DATE: October 9, 2012
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I. GENERAL INFORMATION

A. Background: This change request (CR) focuses on: (1) the contractors' review of the General Services Administration Excluded Parties List System (EPLS) as part of the provider enrollment verification process, and (2) the timeframe for processing tie-in notices and/or approval letters from CMS' regional offices (ROs).

B. Policy: The purpose of this CR is to address the two issues referenced in the previous paragraph.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
8020.1	If the contractor learns via the CMS-855 verification process, a Zone Program Integrity Contractor referral, or other similar means that a particular person or entity is debarred, the contractor shall search the person/entity in the EPLS to see if the EPLS record discloses any associated parties that are debarred.	X	X		X	X	X					National Supplier Clearinghouse (NSC)
8020.1.1	If, per business requirement 8020.1, associated parties are listed, the contractor – after verifying, in accordance with existing CMS instructions, that the associated party is indeed debarred – shall check the Provider Enrollment, Chain and Ownership System (PECOS) to determine whether the party is listed in any capacity.	X	X		X	X	X					NSC
8020.1.1.1	If, per business requirement 8020.1.1, the party is listed in PECOS, the contractor shall take all applicable steps outlined in CMS Pub. 100-08, chapter 15 with respect to revocation proceedings against the party and against any person/entity with	X	X		X	X	X					NSC

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
	whom the party is associated.											
8020.2	With respect to Form CMS-855A and Form CMS-855B transactions for which a post-tie-in notice/approval letter site visit is notrequired (e.g., providers in the "limited" risk category), the contractor shall complete its processing of said notice/letter within 21 calendar days after its receipt of the tie-in/approval notice.	X	X		X	X	X					
8020.3	Regarding Form CMS-855A and Form CMS-855B transactions that require a post-tie-in notice/approval letter site visit, the contractor shall process the tie-in notice/letter within 45 calendar days after its receipt of the notice/letter.	X	X		X	X	X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility						
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Other
		Part A	Part B					
	None							

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

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

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

VI. FUNDING

Section A: For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Carriers:
No additional funding will be provided by CMS; contractor activities are to be carried out with 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 do not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Medicare Program Integrity Manual
Chapter 15 - Medicare Enrollment

Table of Contents
(Rev.433, Issued: 09-07-12)

15.5.3 – Final Adverse Actions

(Rev.433, Issued: 09-07-12, Effective: 10-09, 12, Implementation 10-09-12)

Unless stated otherwise, the instructions in this section 15.5.3 apply to the following sections of the Form CMS-855:

- Section 3
- Section 4A of the CMS-855I
- Section 5
- Section 6

A. Disclosure of Final Adverse Action

If a final adverse action is disclosed on the Form CMS-855, the provider must 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. The documentation must be furnished regardless of whether the adverse action occurred in a State different from that in which the provider seeks enrollment or is enrolled.

NOTE further:

1. Reinstatements - If the person or entity in question was excluded or debarred but has since been reinstated, the contractor shall confirm the reinstatement through the Office of Inspector General (OIG) or, in the case of debarment, through the federal agency that took the action. It shall also ensure that the provider submits written proof of the reinstatement (e.g., reinstatement letter).

2. Revocation Reversals – Medicare revocations that were reversed on appeal need not be reported on the Form CMS-855.

3. Scope of Disclosure – All final adverse actions that occurred under the legal business name (LBN) and tax identification number (TIN) of the disclosing entity (e.g., applicant; Section 5 owner) must be reported. This includes Medicare revocations that: (1) were initiated by a different Medicare contractor in another contractor jurisdiction, and (2) involve a different provider or supplier type. Consider the following examples:

   Example (a) - Smith Pharmacy, Inc. had 22 separately enrolled locations in 2009. Each location was under Smith's LBN and TIN. In 2010, two locations were revoked, leaving 20 locations. Smith submits a Form CMS-855S application for a new location on Jones Street. The two revocations in 2010 must be reported on the Jones Street application. Suppose, however, that each of Smith's locations had its own LBN and TIN. The Jones Street application need not disclose the two revocations from 2010.

Example (b) - A home health agency (HHA), hospice and hospital are enrolling under Corporation X's LBN and TIN. X is listed as the provider in section 2 of each applicant's Form CMS-855A. All three successfully enroll. Six months later, Company X's billing privileges for the HHA are revoked. Both the hospice and the hospital must report the revocation via a Form CMS-855A change request because the revocation occurred under the provider's LBN and TIN. Assume now that X seeks to enroll an ambulatory surgical center (ASC) under X's LBN and TIN. The HHA revocation would have to be reported in section 3 of the ASC's initial Form CMS-855B.

Example (c) – Company Y is listed as the provider/supplier for two HHAs and 2 suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS). These 4 providers/suppliers are under Y's LBN and TIN. Each provider/supplier is located in a different State. All are enrolled. Y's billing privileges for one of the DMEPOS suppliers are revoked. Y now seeks to enroll an ASC in a fifth State. Y must disclose the DMEPOS revocation on the ASC's initial Form CMS-855, even though the revocation: (1) was done by a Medicare contractor other than that with which the ASC seeks enrollment, and (2) occurred in a State different from that in which the ASC is located.

Example (d) – Company Alpha is listed as an owner in section 5 of the Form CMS-855A. Alpha operates two health care providers – Y and Z - under its LBN and TIN. Y was subject to a General Services Administration debarment, which ended in 2009. The debarment would have to be reported in section 5, since it occurred under Z's LBN and TIN.

4. Timeframe – With the exception of the felony convictions identified in #1 under "Convictions" in section 3 of the Form CMS-855, all final adverse actions must be reported regardless of when they occurred.

5. Corporate Integrity Agreements (CIAs) – CIAs need not be disclosed on the Form CMS-855.

6. Evidence to Indicate Adverse Action – There may be instances where the provider states in section 3, 4A of the CMS-855I, 5, and/or 6 that the person or entity has never had a final adverse action imposed against him/her/it, but the contractor finds evidence to indicate otherwise. In such cases, the contractor shall contact its Provider Enrollment Operations Group Business Function Lead (PEOG BFL) for guidance.

B. Prior Approval

If a current exclusion or debarment is disclosed on the Form CMS-855, the contractor shall deny the application in accordance with the instructions in this chapter. Prior approval from PEOG is not necessary. If any other final adverse action is listed, the contractor shall refer the matter to its PEOG BFL for guidance.

C. Review of the Provider Enrollment, Chain and Ownership System (PECOS)

If the contractor denies an application or revokes a provider based on a final adverse action, the

contactor shall search PECOS (or, if the provider is not in PECOS, the contractor's internal system) to determine:

- Whether the person/entity with the adverse action has any other associations (e.g., is listed in PECOS as an owner of three Medicare-enrolled providers), or

- If the denial/revocation resulted from an adverse action imposed against an owner, managing employee, director, etc., of the provider, whether the person/entity in question has any other associations (e.g., a managing employee of the provider is identified as an owner of two other Medicare-enrolled HHAs).

If such an association is found and, per 42 CFR §424.535, there are grounds for revoking the billing privileges of the other provider, the contractor shall initiate revocation proceedings with respect to the latter.

If the "other provider" is enrolled with a different contractor, the contractor shall notify the latter - via fax or e-mail – of the situation, at which time the latter shall take the revocation action. To illustrate, suppose John Smith attempted to enroll with Contractor X as a physician. Smith is currently listed as an owner of Jones Group Practice, which is enrolled with Contractor Y. Contractor X discovers that Smith was recently convicted of a felony. X therefore denies Smith's application. X must also notify Y of the felony conviction; Y shall then revoke Jones' billing privileges per 42 CFR § 424.535(a)(3).

D. Chain Home Offices, Billing Agencies, and HHA Nursing Registries

If the contractor discovers that an entity listed in sections 7, 8, or 12 of the Form CMS- 855 has had a final adverse action imposed against it, the contractor shall contact its PEOG BFL for guidance.

E. General Services Administration Excluded Parties List System (EPLS)

When an entity or individual is listed as debarred in the EPLS, the EPLS record may identify associated entities and persons that are also debarred. To illustrate, suppose John Smith is identified as debarred. The EPLS record may also list individuals and entities associated with John Smith that are debarred as well, such as "John Smith Company," "Smith Consulting," "Jane Smith," and "Joe Smith."

If the contractor learns via the CMS-855 verification process, a Zone Program Integrity Contractor referral, or other similar means that a particular person or entity is debarred, the contractor shall search the person/entity in the EPLS to see if the EPLS record discloses any associated parties that are debarred. If associated parties are listed, the contractor – after verifying, via the instructions in this chapter, that the associated party is indeed debarred – shall check PECOS to determine whether the party is listed in any capacity. If the party is listed, the contractor shall take all applicable steps outlined in this chapter with respect to revocation proceedings against the party and against any persons/entities with whom the party is associated. For instance, using our example above, if the contractor confirms that Jane Smith is

debarred and PECOS shows Jane Smith as an owner of Entity X, the contractor shall, as applicable, initiate revocation proceedings against X.

15.7.7.2.1 – Processing Tie-In Notices/*Approval Letters*

(Rev.433, Issued: 09-07-12, Effective: 10-09, 12, Implementation 10-09-12)

With respect to Form CMS-855A transactions for which a post-tie-in notice/approval letter site visit is not required (e.g., providers in the "limited" risk category), the contractor shall complete its processing of said *notice/letter w*ithin 21 calendar days after its receipt of the tie-in/approval notice. For purposes of this requirement, the term "processing" *includes all steps taken by the contractor's enrollment and non-enrollment units (e.g. financial area, reimbursement area) to establish the provider's ability to bill Medicare such as, but not limited to:*

1. Entering all relevant data into *the Provider Enrollment, Chain and Ownership System (PECOS).*

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

3. Facilitating the provider's electronic funds transfer and electronic data interchange arrangements.

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

The 21-day period begins on the day that the contractor receives the tie-in notice and ends on the day that the contractor notifies the provider that it can commence billing.

Regarding *Form CMS-855A transactions that require a post-tie-in notice/approval letter site visit, the contractor shall process the tie-in notice/letter within 45 calendar days of its receipt of the notice/letter. This is to account for the additional time needed for the site visit to be performed.*

15.7.8.3.1 – Processing Tie-In Notices/*Approval Letters*

(Rev.433, Issued: 09-07-12, Effective: 10-09, 12, Implementation 10-09-12)

With respect to Form CMS-855B transactions for which a post-tie-in notice/approval letter site visit is not required, the contractor shall complete its processing of said *notice/letter w*ithin 21 calendar days after its receipt of the tie-in/approval notice. For purposes of this requirement, the term "processing" *includes all steps taken by the contractor's enrollment and non-enrollment units (e.g. financial area, reimbursement area) to establish the supplier's ability to bill Medicare such as, but not limited to:*

1. Entering all relevant data into *the Provider Enrollment, Chain and Ownership System (PECOS).*

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

3. Facilitating the supplier's electronic funds transfer and electronic data interchange arrangements.

4. Notifying the supplier (via any mechanism the contractor chooses) that it may begin billing.

The 21-day period begins on the day that the contractor receives the tie-in notice and ends on the day that the contractor notifies the provider that it can commence billing.

Regarding *Form CMS-855B transactions that require a post-tie-in notice/approval letter site visit, the contractor shall process the tie-in notice/letter within 45 calendar days of its receipt of the notice/letter. This is to account for the additional time needed for the site visit to be performed.*