CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 277	**Date: December 19, 2008**
	Change Request 6097

SUBJECT: Additional Provider Enrollment Verification and Program Integrity Activities

I. SUMMARY OF CHANGES: This change request enhances data verification procedures for certain CMS-855 transactions, and supplementary program integrity activities.

NEW / REVISED MATERIAL
EFFECTIVE DATE: January 20, 2009
IMPLEMENTATION DATE: January 20, 2009

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	10/3.2/Returning the Application
R	10/4.2.2/Licenses and Certifications
R	10/4.3/Adverse Legal Actions/Convictions
R	10/4.4.1/Section 4 of the CMS-855A
R	10/4.7/Chain Organizations
R	10/4.19.5/Supervising Physicians
R	10/5.5.1/Jurisdictional Issues
R	10/5.5.2.5/EFT Payments and CHOWs
N	10/5.5.2.5.1/Pre-Approval Informational Changes
N	10/5.5.3.1/Processing Tie-In Notices
R	10/5.6.2.1.2/EFT Payments and CHOWs
N	10/5.6.3.1/Processing Tie-In Notices
N	10/5.7/Special Program Integrity Procedures
N	10/5.7.1/Special Procedures for Physicians and Non-Physician

	Practitioners
N	10/9.1/Supplementary Revalidation Activities
R	10/17.2/Release of Information

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: 277	Date: December 19, 2008	Change Request: 6097

SUBJECT: Additional Provider Enrollment Verification and Program Integrity Activities

Effective Date: January 20, 2009
Implementation Date: January 20, 2009

I. GENERAL INFORMATION

A. Background: This change request (CR) enhances data verification procedures for certain CMS-855 transactions, and supplementary program integrity activities.

B. Policy: The purpose of this CR is to incorporate into chapter 10 enhanced CMS-855 verification procedures and additional program integrity activities.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6097.1	If the contractor denies an application or revokes a provider based on an adverse legal action, the contactor shall search Provider Enrollment, Chain and Ownership System [PECOS] (or, if the provider is not in PECOS, the contractor's internal systems) to determine: (1) whether the provider has any other associations (e.g., is listed in PECOS as an owner of three Medicare-enrolled providers), or (2) 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).	X		X	X	X					
6097.1.1	With respect to 6097.1, 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.	X		X	X	X					
6097.1.2	With respect to 6097.1.1, 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	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 FISS	MCS	VMS	CWF	OTHER
	which time the latter shall take the necessary revocation action.										
6097.2	If the contractor is unable to perform the HHA site visit recommended in section 4.4.1, of chapter 10, and elects to proceed with a recommendation to the State agency, the contractor shall clearly articulate in its recommendation letter its concerns about potential commingling.	X		X		X					
6097.3	In addition to the tasks currently specified in section 4.19.5(B) of chapter 10, the contractor shall ensure that each supervisory physician: (1) is not currently excluded or debarred, and (2) does not have a felony conviction within the last 10 years.	X			X						
6097.4	Once an audit intermediary finishes processing a CMS-855 initial enrollment application, change of information, voluntary termination, EFT request, or any other CMS-855/588 transaction, the contractor shall fax a copy of the applicable CMS-855/588 paperwork to the claims intermediary (if, of course, the audit and claims intermediaries are different).	X		X		X					
6097.5	In a change of ownership (CHOW), the contractor shall return any CMS-855 request from the old or new owner to change the EFT account or special payment address to that of the new owner prior to the issuance of the tie-in notice.	X		X	X	X					
6097.6	In a CHOW, if – prior to the issuance of the tie-in notice – the contractor receives from the seller a CMS-855 request to change any of the provider's enrollment data, the contractor shall return the application to the seller if any of the information specified in section 5.5.2.5.1(A)(2-4), of chapter 10, is implicated.	X		X		X					
6097.7	In a CHOW, if – prior to the issuance of the tie-in notice – the contractor receives from the buyer a CMS-855 request to change any of the provider's enrollment data, the contractor shall return the application to the buyer.	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	
6097.8	Within 21 calendar days after its receipt of a tie-in or approval notice, the contractor shall complete its processing of said notice.	X		X	X	X					
6097.9	When processing a provider's CMS-855 request to change its practice location address, the contractor shall compare the signature on the application with the same person's signature already on file to ensure that the signatures match.	X		X	X	X					
6097.9.1	In the situation described in 6097.9, if the signatures do not match, the contractor shall request additional information from the signatory to confirm his or her identity.	X		X	X	X					
6097.9.1.1	In the situation described in 6097.9.1, if the individual fails to submit this information or if the contractor determines that the supporting documentation does not verify the person's identity, the contractor shall deny the application.	X		X	X	X					
6097.9.1.2	If, in the situation described in 6097.9, the person's signature on the CMS-855A or CMS-855B 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.	X		X	X	X					
6097.10	When processing a provider's CMS-855 request to change its practice location address, the contractor shall contact the practice location currently associated with the provider in PECOS or MCS to verify that the provider is no longer there and did in fact move.	X		X	X	X					
6097.10.1	If, in the situation described in 6097.10, the provider did move, the contractor shall request that the provider fax to the contractor a copy of his/her driver's license or – in the case of a CMS-855A or CMS-855B application - a copy of a phone bill/power bill containing the entity's new LBN or DBA name and its new address.	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	
6097.11	When processing a provider's CMS-855 request to change its correspondence address or special payments address, the contractor shall compare the signature on the application with the same person's signature already on file to ensure that the signatures match.	X		X	X	X					
6097.11.1	In the situation described in 6097.11, if the signatures do not match, the contractor shall request additional information from the signatory to confirm his or her identity.	X		X	X	X					
6097.11.1.1	In the situation described in 6097.11.1, if the individual fails to submit this information or if the contractor determines that the supporting documentation does not verify the person's identity, the contractor shall deny the application.	X		X	X	X					
6097.11.1.2	If, in the situation described in 6097.11, the person's signature on the CMS-855A or CMS-855B 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.	X		X	X	X					
6097.12	When processing a provider's CMS-855 request to change its correspondence address or special payments address, the contractor shall contact the provider (or, for a CMS-855A or CMS-855B application, an authorized or delegated official thereof) to verify the change.	X		X	X	X					
6097.13	When processing a provider's CMS-588 request to change its bank name, depository routing transit number, or depository account number, the contractor shall compare the signature thereon with the same person's signature already on file to ensure that the signatures match.	X		X	X	X					
6097.13.1	In the situation described in 6097.13, if the signatures do not match, the contractor shall request additional information from the signatory to confirm his or her identity.	X		X	X	X					
6097.13.2	In the situation described in 6097.13.1, if the individual	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	
	fails to submit this information or if the contractor determines that the supporting documentation does not verify the person's identity, the contractor shall deny the application.										
6097.13.3	If, in the situation described in 6097.13, the person's signature on the CMS-588 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.	X		X	X	X					
6097.14	When processing a provider's CMS-588 request to change its bank name, depository routing transit number, or depository account number, the contractor shall contact the provider (or, for a CMS-855A or CMS-855B application, an authorized or delegated official thereof) to verify the change.	X		X	X	X					
6097.15	When processing a CMS-855 reactivation or revalidation application, the contractor shall compare the signature thereon with the same person's signature already on file to ensure that the signatures match.	X		X	X	X					
6097.15.1	In the situation described in 6097.15, if the signatures do not match, the contractor shall request additional information from the signatory to confirm his or her identity.	X		X	X	X					
6097.15.2	In the situation described in 6097.15.1, if the individual fails to submit this information or if the contractor determines that the supporting documentation does not verify the person's identity, the contractor shall deny the application.	X		X	X	X					
6097.15.3	In the situation described in 6097.15, if the person's signature on the CMS-855A or CMS-855B 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.	X		X	X	X					
6097.16	When processing a CMS-855 reactivation or revalidation application, if the practice location address listed thereon is different from the one currently	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	
	associated with the provider in PECOS or MCS, the contractor shall abide by the instructions in section 5.7(A) of this manual.										
6097.17	When processing a CMS-855 reactivation or revalidation application, if the correspondence address or special payment address listed thereon is different from the one currently associated with the provider in PECOS or MCS, the contractor shall contact abide by the instructions in section 5.7(B) of chapter 10.	X		X	X	X					
6097.18	When processing a CMS-855 reactivation application, the contractor shall request that the provider furnish a copy of a claim that it plans to submit upon the reactivation of its billing privileges. (Alternatively, the provider may submit on letterhead the following information regarding a beneficiary to whom the provider has furnished services and for whom it will submit a claim: (1) beneficiary name, (2) health insurance claim number (HICN), (3) date of service, and (4) phone number.)	X		X	X	X					
6097.19	If a physician or non-physician practitioner who has reassigned (or is currently reassigning) all of his or her benefits attempts to enroll as a sole proprietorship or the sole owner of his or her professional corporation, association or LLC, the contractor shall undertake the activities described in section 5.7(E) of chapter 10.	X			X						
6097.20	In conducting the verification activities described in section 16 of chapter 10, if the contractor believes that a case of identify theft or other fraudulent activity likely exists (e.g., physician or practitioner indicates that he or she is <u>not</u> establishing a new practice location or changing his or her EFT information, and that the application submitted in his/her name is false), the contractor shall deny the application and refer the matter to the Program Safeguard Contractor (PSC) or Zone Program Integrity Contractor (ZPIC).	X		X	X	X					PSCs; ZPICs
6097.21	No later than the 15th day of each month, the contractor shall review State licensing board information for each State within its jurisdiction to determine whether any	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	
	of its currently enrolled practitioners have, within the previous 60 days, had any of the licensure actions described in section 5.7.1(A) of chapter 10 imposed against them										
6097.22	When a practitioner submits a CMS-855I application to either: (1) add a practice location in a new State, or (2) relocate to a new State entirely, the contractor that received the application shall review State licensing board information for the "prior" State to determine if any of the adverse actions described in section 5.7.1(B), of chapter 10, are present and, if so, whether the provider properly reported this information.	X			X						
6097.22.1	If, in the situation described in 6097.22, the provider failed to properly report this information, the contractor shall establish the applicable enrollment bars identified in section 5.7.1(B), of chapter 10.	X			X						
6097.23	If the contractor receives a CMS-855I from a practitioner who was once enrolled in Medicare but who has not been enrolled with any Medicare contractor for the previous 2 years, the contractor shall verify with the State where the practitioner last worked whether the practitioner was convicted of a felony or had his or her license suspended or revoked.	X			X						
6097.24	Whether as part of an initial enrollment or a change request, if the practitioner wants to establish an EFT account: (1) in a State other than where the practice location is listed, or (2) located at an institution that is more than 50 miles from any of the supplier's existing, in-State practice locations, the contractor shall contact the practitioner to verify that this is indeed his or her intention.	X			X						
6097.25	If, in the situation described in 6097.24, the practitioner indicates that he or she never submitted such a request, the contractor shall deny the enrollment/change application and refer the matter to the program safeguard contractor (PSC) or zone program integrity contractor (ZPIC).	X			X						PSCs; ZPICs

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	
6097.26	If, as of the last day of the eighth month of the fiscal year for legacy contractors (May 31) or the current contract year for A/B MAC contractors, the contractor's provider enrollment workload <u>and</u> costs are both less than what was projected to CMS at the beginning of the fiscal/contract year, the contractor shall undertake revalidation efforts commensurate with the amount of surplus funding.	X		X	X	X					
6097.26.1	In conducting revalidation activities as described in 6097.26, the contractor shall first revalidate those providers that do not have an established enrollment record in PECOS, after which the contractor's revalidation priorities shall be carried out in accordance with the instructions in section 9.1, of chapter 10.	X		X	X	X					
6097.27	Once the provider has submitted an enrollment application (as well as after it has been enrolled), the contractor shall not release – either orally or in writing - provider-specific data to any other person or entity, with the exception of those instances outlined in section 17.2, of chapter 10.	X		X	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):*
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

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

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

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(Rev. 277, 12-19-08)

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9.1 – Supplementary Revalidation Activities

3.2 – Returning the Application

(Rev. 277; Issued: 12-19-08; Effective/Implementation Date: 01-20-09)

A. Immediate Returns

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 CMS-855 application;
- 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 of the forms needed to process a reassignment package within 15 calendar days of receipt (as described in section 5.4 of this manual);
- The applicant sent its CMS-855 to the wrong contractor (e.g., the application was sent to Carrier X instead of Carrier Y);
- 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. (This only applies to fiscal intermediaries.)
- The application was faxed or e-mailed in;
- The contractor received the application more than 30 days prior to the effective date listed on the application. (This does not apply to certified providers, ASCs, or portable x-ray suppliers.);

- The contractor can confirm that the provider submitted a new enrollment application prior to the expiration of the time period in which the provider is entitled to appeal the denial of its previously submitted application;

- The contractor discovers or determines that the provider submitted a CMS-855 application for the sole purpose of enrolling in Medicaid; the only exception to this is when the provider is required to submit a Medicare cost report in order to participate in a State Medicaid program;

- The CMS-855 is not needed for the transaction in question. (A common example is an enrolled physician who wants to change his reassignment of benefits from one group to another group and submits a CMS 855I and a CMS 855R. As only the CMS 855R is needed, the CMS-855I shall be returned.);

- The CMS-588 was sent in as a stand-alone change of information request (i.e., it was not accompanied by a CMS-855) but was (1) unsigned, (2) undated, or (3) contained a copied, stamped, or faxed signature.

- *The circumstances in sections 5.5.2.5, 5.5.2.5.1, or 5.6.2.1.2 of this manual apply.*

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.

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. Returning the application on this basis alone is not permitted.

B. Procedures for Returning the 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.

- It shall not 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).

C. EFT Agreements

A non-signature on the CMS-588 EFT form (assuming that it is submitted in conjunction with a CMS-855 initial application or change request) is not grounds for returning the entire application package. The contractor shall simply develop for the signature using the procedures cited in section 5.3 of this manual. However, the EFT form must contain an original signature when it is finally submitted. Faxed EFT agreements are not permitted. (This is an exception to the general rule in section 5.3 that contractors can receive additional or clarifying information via fax.) Once the provider submits an EFT agreement with an original signature, any additional or clarifying information the contractor needs with respect to that document can be submitted by the provider via fax. (The provider must still, of course, furnish a new signature when it adds the new information.)

4.2.2 – Licenses and Certifications

(Rev. 277; Issued: 12-19-08; Effective/Implementation Date: 01-20-09)

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

A. CMS-855B and CMS-855I

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

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

Verification can be performed by reviewing the licensure documentation submitted by the applicant. If the contractor, in its general review of Qualifier.net, finds inconsistencies between the data on the license and the data in Qualifier.net, the contractor 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 contractor 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 contractor shall still ensure, however, that the supplier meets all applicable State and Medicare requirements.

The contractor shall also adhere to the following:

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

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

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

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

- **Temporary Licenses:** If the supplier submits a temporary license, the contractor shall note the expiration date in PECOS. Should the supplier fail to submit the permanent license after the temporary license expiration date, the contractor shall initiate revocation procedures. (A temporary permit – one in which the applicant is not yet fully licensed and must complete a specified number of hours of practice in order to obtain the license – is not acceptable.)

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

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

See section 5.7.1, of this manual for special instructions related to periodic license reviews and certain program integrity matters.

B. CMS-855A

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

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

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

4.3 – Adverse Legal Actions/Convictions

(Rev. 277; Issued: 12-19-08; Effective/Implementation Date: 01-20-09)

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 a felony or misdemeanor conviction 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 Program Safeguard Contractor (PSC) or Zone Program Integrity Contractor (ZPIC)*, if necessary.) In its referral to CMS, the contractor shall furnish a brief explanation of the matter along with the applicable section of the CMS-855 (e.g., section 3, section 5). The contractor shall neither approve nor deny the application until DPSE issues a final directive to the contractor.

If the applicant is excluded or debarred, the contractor shall deny the application in accordance with the instructions in this manual; prior approval from DPSE is not necessary. If any other adverse action is listed, the contractor shall refer the matter to its DPSE contractor liaison for instructions.

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. It is extremely important that the contractor obtain such documentation, regardless of whether the adverse action occurred in a State different from that in which the provider currently seeks enrollment. (In other words, all adverse actions must be fully disclosed, irrespective of where the action took place.) 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) 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 DPSE for further instructions. The contractor shall neither approve nor deny the application until DPSE issues a final directive, which could include an instruction to deny the application based on false information furnished by the applicant. (See section 6.2 of this manual for further details on the handling of potentially falsified applications.)

If the contractor denies an application or revokes a provider based on an adverse legal action, the contactor shall search PECOS (or, if the provider is not in PECOS, the contractor's internal systems) to determine: (1) whether the provider has any other associations (e.g., is listed in PECOS as an owner of three Medicare-enrolled providers), or (2) 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).

Chain Home Offices, Billing Agencies, and HHA Nursing Registries

If a Qualifier.net search of the entities listed in sections 7, 8, or 12 of the CMS 855 indicate adverse legal history, the contractor shall handle the matter in accordance with the instructions in this section 4.3.

4.4.1 – Section 4 of the CMS-855A

(Rev. 277; Issued: 12-19-08; Effective/Implementation Date: 01-20-09)

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

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

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

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

Verification of HHA Sites

If the contractor receives an application from an HHA that has the same general practice location address as another enrolled (or enrolling) HHA and the contractor has reason to suspect that the HHAs may be concurrently operating out of the same suite or office, it is strongly recommended that the contractor perform a site visit (per section 5.3 of this manual) to determine whether the two providers are operating separately. If a site visit cannot be performed and the contractor elects to proceed with a recommendation to the State agency, the contractor shall clearly articulate in its recommendation letter any concerns about potential commingling.

4.7 – Chain Organizations

(Rev. 277; Issued: 12-19-08; Effective/Implementation Date: 01-20-09)

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

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

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

The contractor shall ensure that:

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

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

The contractor 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 4.3 of this manual.

For more information on chain organizations, refer to:

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

- 42 CFR § 421.404

- CMS change request 5720

4.19.5 – Supervising Physicians

(Rev. 277; Issued: 12-19-08; Effective/Implementation Date: 01-20-09)

A. General Principles

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

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

Of course, not every supervising physician has to be responsible for all of these functions. For instance, one supervising physician can be responsible for the operation and calibration of equipment, while other supervising physicians can be responsible for test supervision and the qualifications of non-physician personnel. The basic requirement, however, is that all the supervisory physician functions must be properly met at each location, regardless of the number of physicians involved. This is particularly applicable to mobile IDTF units that are allowed to use different supervisory physicians at different locations. They may have a different physician supervise the test at each location. The physicians used need only meet the proficiency standards for the tests they are supervising.

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

B. Information about the Supervising Physicians

The 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, (2) is Medicare enrolled, and *(3) is not currently excluded or debarred*. The physician(s) need not necessarily be Medicare enrolled in the State where the IDTF is enrolled.

In addition:

- The 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.
- 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

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 previously, the boxes can be checked through the use of more than one physician.

D. Attestation Statement for Supervising Physicians

A separate attestation statement must be completed and signed by each supervisory physician listed. If Question E2 is not completed, the 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.

5.5.1 - Jurisdictional Issues

(Rev. 277; Issued: 12-19-08; Effective/Implementation Date: 01-20-09)

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, however, they will be different; this often happens with provider-based entities, whereby the provider's enrollment application will be processed by the parent provider's intermediary (audit intermediary) and its claims will be paid by a different intermediary (claims intermediary).

In situations where the audit and claims intermediaries differ, the audit 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, change of information, voluntary termination, EFT request, or any other CMS-855/588 transaction, it shall fax a copy of the applicable CMS-855/588 paperwork to the claims intermediary.

Moreover, in situations where the audit intermediary is different from the claims intermediary, the audit intermediary shall fax a copy of all tie-in and tie-out notices 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 shall 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 copies of tie-in and tie-out notices 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.

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

B. Provider Nomination

With respect to issues regarding provider nomination and changes of intermediaries, the contractor shall adhere to the instructions in Publication 100-04, chapter 1, sections 20 through 20.5.1, and CMS change request 5720.

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

5.5.2.5 - EFT Payments and CHOWs

(Rev. 277; Issued: 12-19-08; Effective/Implementation Date: 01-20-09)

In a CHOW, the *contractor* shall continue to pay the old owner until it receives the tie-in notice from the RO. Hence, any *application* from the old or new owner to change the EFT account *or special payment address* to that of the new owner shall be *returned in accordance with section 3.2 of this manual.* It is ultimately the responsibility of the old and new owners to work out any payment arrangements between themselves while the CHOW is being processed by the intermediary and the RO.

5.5.2.5.1 – Pre-Approval Informational Changes

(Rev. 277; Issued: 12-19-08; Effective/Implementation Date: 01-20-09)

A. Seller

If – prior to the issuance of the tie-in notice – the contractor receives from the seller a CMS-855 request to change any of the provider's enrollment data, the contractor shall, per section 3.2 of this manual, return the application to the seller if the information in question involves changing the provider's:

1. EFT or special payment address information to that of the buyer (as described in section 5.5.2.5 of this manual);

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

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

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

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

B. Buyer

If – prior to the issuance of the tie-in notice – the contractor receives from the buyer a CMS-855 request to change any of the provider's existing enrollment information, the contractor shall return the application per section 3.2 of this manual. Until the tie-in is issued, the seller remains the owner of record; hence, the buyer has no standing to submit CMS-855 changes on behalf of the provider.

5.5.3.1 – Processing Tie-In Notices

(Rev. 277; Issued: 12-19-08; Effective/Implementation Date: 01-20-09)

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

1. *Entering all relevant data into PECOS;*

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

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

5.6.2.1.2 - EFT Payments and CHOWs

(Rev. 277; Issued: 12-19-08; Effective/Implementation Date: 01-20-09)

In a CHOW, the contractor shall continue to pay the old owner until it receives the tie-in/approval notice from the RO. Hence, any *application* from the old or new owner to change the EFT account *or special payment address* to that of the new owner shall be *returned in accordance with section 3.2 of this manual.* It is ultimately the responsibility of the old and new owners to work out any payment arrangements between themselves while the CHOW is being processed by the contractor and the RO.

If – pursuant to the CHOW – the seller submits a CMS-855B voluntary termination, the contractor shall contact and explain to the seller that the ASC/PXRS will not receive any payments until the RO approves the CHOW. (This is because, as explained above, payments must be sent to the seller until the tie-in/approval letter is sent). If the seller insists that its application be processed, the contractor shall process said termination; however, it shall first notify the facility/new owner and explain that payments will cease once the seller's termination is effective. In fact, it is highly recommended that, upon receipt of a CMS-855B CHOW application, the contractor contact the supplier to notify it of the payment rule identified in the previous paragraph.

5.6.3.1 – Processing Tie-In Notices

(Rev. 277; Issued: 12-19-08; Effective/Implementation Date: 01-20-09)

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

1. Entering all relevant data into PECOS

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

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

5.7 – Special Program Integrity Procedures
(Rev. 277; Issued: 12-19-08; Effective/Implementation Date: 01-20-09)

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

- *Changes in the provider's practice location*

- *Changes in provider's correspondence or special payment address*

- *On the CMS-588, changes in the provider's bank name, depository routing transit number, or depository account number*

- *Reactivations*

The purpose of these instructions is to ensure that the Medicare billing privileges of physicians, non-physician practitioners, and organizational providers/suppliers are protected and that Medicare only pays qualified individuals and organizations. Note that the instructions in this section 5.7 are in addition to, and not in lieu of, all other verification instructions contained in this manual. Also, unless otherwise stated, section 5.7 applies to the CMS-855A, the CMS-855B and the CMS-855I.

A. Change in Practice Location Address

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

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

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

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

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

B. Change in Correspondence or Special Payments Address

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

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

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

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

C. Change of EFT Information

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

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

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

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

D. Reactivations and Revalidations

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

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

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

2. If the: (a) practice location address or (b) correspondence/special payment address on the application is different than that which is currently associated with the provider in PECOS or MCS, the contractor shall abide by the instructions in subsections A and B above, respectively.

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

E. Reassignment of All Benefits

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

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

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

F. Referral to PSCs or ZPICs

In conducting the verification activities described in this section 16, if the contractor believes that a case of identify theft or other fraudulent activity likely exists (e.g., physician

or practitioner indicates that he or she is _not_ *establishing a new practice location or changing his or her EFT information, and that the application submitted in his/her name is false), the contractor shall deny the application and refer the matter to the PSC or ZPIC.*

5.7.1 - Special Procedures for Physicians and Non-Physician Practitioners
(Rev. 277; Issued: 12-19-08; Effective/Implementation Date: 01-20-09)

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

For purposes of this section 5.7.1, the term "practitioner" includes both physicians and non-physician practitioners. In addition, the instructions in this section 5.7.1 apply only to these practitioners.

A. Monthly Reviews

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

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

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

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

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

B. Relocation to a New State

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

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

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

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

and did not report the adverse action in section 3 of the CMS-855I, the contractor shall deny the enrollment application and establish a three-year enrollment bar.

C. Break in Medical Practice

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

D. Distant EFT Account

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

E. ***State Relationships***

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

9.1 – Supplementary Revalidation Activities
(Rev. 277; Issued: 12-19-08; Effective/Implementation Date: 01-20-09)

If, as of the last day of the eighth month of the fiscal year for legacy contractors (May 31) or the current contract year for A/B MAC contractors, the contractor's provider enrollment workload and costs are both less than what was projected to CMS at the beginning of the fiscal/contract year, the contractor shall undertake revalidation efforts commensurate with the amount of surplus funding. In doing so, the contractor shall first revalidate those providers that do not have an established enrollment record in PECOS.

Revalidation of the remaining providers shall be conducted in roughly the following order:

1. *Providers that have not updated their enrollment information within the previous 5 years (i.e., have not submitted a CMS-855 change of information within that time span).*

2. *High-risk providers (e.g., provider is located in a historically high-risk metropolitan area or is of a high-risk provider/supplier type).*

3. *Providers that are not receiving payments via EFT.*

4. *High-reimbursement providers.*

17.2 - Release of Information

(Rev. 277; Issued: 12-19-08; Effective/Implementation Date: 01-20-09)

On October 13, 2006, CMS published System of Records Notice for the Provider Enrollment, Chain and Ownership System (PECOS) in the Federal Register. Consistent with this notice, once the provider has submitted an enrollment application (as well as after it has been enrolled), the contractor shall not release – either orally or in writing - provider-specific data to any other person or entity. This includes, but is not limited to, national or State medical associations or societies, clearinghouses, billing agents, provider associations, or any person within the provider's organization other than the provider's authorized official (section 15 of the CMS-855), delegated official (section 16) or contact person (section 13). The only exceptions to this policy are:

- *A routine use found in the aforementioned System of Records applies;*

- *The provider (or, in the case of an organizational provider, an authorized or delegated official): (1) furnishes a signed written letter on the provider's letterhead stating that the release of the provider data is authorized, <u>and</u> (2) the contractor has no reason to question the authenticity of the person's signature.*

- *The release of the data is specifically authorized in some other CMS instruction or directive.*

(These provisions also apply in cases where the provider requests a copy of any CMS-855 paperwork the contractor has on file.)

It is recommended that the contractor notify the provider of the broad parameters of the aforementioned policy as early in the enrollment process as *possible.*

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.

- 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.