CMS Manual System	Department of Health & Human Services
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services
Transmittal 272	Date: NOVEMBER 7, 2008
	Change Request 6151

SUBJECT: Clarification of Provider Enrollment Procedures Involving Certified Suppliers and Providers

I. SUMMARY OF CHANGES: This change request clarifies certain policies related to the processing of CMS-855 applications submitted by certified suppliers and providers. Specifically, these instructions outline situations in which the contractor must refer particular matters to State agencies and regional offices.

NEW / REVISED MATERIAL
EFFECTIVE DATE: December 8, 2008
IMPLEMENTATION DATE: December 8, 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	10/4.4.2/Section 4 of the CMS-855B
R	10/5.5.2.3/Processing CHOW Applications
R	10/5.5.3/Tie-In Notices
R	10/5.5.5/State Surveys and the CMS-855A
R	10/5.6.3/ASC/PXRS Tie-In Notices
R	10/5.6.5/State Surveys and the CMS-855B
R	10/7.2/Special Instructions for Certified Providers, ASCs, and Portable X-ray Suppliers
R	10/11.4/Non-Participating Emergency Hospitals, Veterans Administration (VA) Hospitals, and Department of Defense (DOD) Hospitals
R	10/11.5/Carrier Processing of Hospital Applications
R	10/13.1/CMS or Contractor Issued Deactivations

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: 272	Date: November 7, 2008	Change Request: 6151

SUBJECT: Clarification of Provider Enrollment Procedures Involving Certified Suppliers and Providers

Effective Date: December 8, 2008
Implementation Date: December 8, 2008

I. GENERAL INFORMATION

A. Background: This change request clarifies certain policies related to the processing of CMS-855 applications submitted by certified suppliers and providers. Specifically, these instructions outline situations in which contractors must refer particular CMS-855 transactions to State agencies and regional offices (ROs).

B. Policy: The purpose of this change request is to clarify the relationship between contractors and the States/ROs with respect to the processing of CMS-855 applications submitted by certified suppliers and providers.

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	
6151.1	The contractor shall note that if an ambulance company will be furnishing all of its services in the same contractor jurisdiction, the supplier must list: (1) each site at which its vehicles are garaged in section 4A of the CMS-855B; (2) each site from which its personnel are dispatched in section 4A of the CMS-855B; and (3) its base of operations – which, for ambulance companies, is their primary headquarters – in section 4E of the CMS-855B.	X			X						
6151.2	As the seller's CMS-855A change of ownership (CHOW) application is essentially the equivalent of a CMS-855 voluntary termination submission, the contractor shall not require the old owner to submit a separate CMS-855 voluntary termination along with its CMS-855A CHOW application.	X		X		X					
6151.3	With respect to applications submitted by certified suppliers and providers, once the contractor has made its recommendation for approval to the State/RO, any inquiry the contractor receives from the	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	
	provider/supplier regarding the status of its request for Medicare participation shall be referred to the State or RO.										
6151.4	With respect to the list of transactions in section 5.5.3(B)(i) of Pub. 100-08, chapter 10 (hereinafter referred to as "chapter 10"), the contractor shall make a recommendation for approval to the State/RO and await final approval from the RO before switching the Provider Enrollment, Chain and Ownership System (PECOS) record to "approved."	X		X		X					
6151.5	For those transactions identified in section 5.5.3(B)(ii), of chapter 10, the contractor shall notify the provider via letter, e-mail, or telephone that the change has been made and shall switch the PECOS record to "approved."	X		X		X					
6151.5.1	In the situation described in 6151.5, the contractor shall notify the State and RO of the changed information (via any mechanism it chooses, including copying the State/RO on the notification letter or e-mail) no later than 10 calendar days after it has completed processing the transaction.	X		X		X					
6151.6	In situations where the provider submits a: (1) CMS-855A reactivation, (2) CMS-855A revalidation, or (3) full CMS-855A as part of a change of information, the contractor shall make a recommendation to the State/RO and switch the PECOS record to "approval recommended" only if the application contains new/changed data falling within the category of items listed in section 5.5.3(B)(i) of chapter 10.	X		X		X					
6151.6.1	In situations where the provider submits a: (1) CMS-855A reactivation, (2) CMS-855A revalidation, or (3) full CMS-855A as part of a change of information, if the application contains new/changed data falling within the category of items in section 5.5.3(B)(ii) of chapter 10, the contractor shall switch the PECOS record to "approved" and notify the State/RO of the changed/new information (via any mechanism it chooses, including copying the State/RO on the	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	
	notification letter or e-mail) no later than 10 calendar days after it has completed processing the transaction.										
6151.7	The contractor shall note that if it receives a tie-out notice from the RO that involuntarily terminates the provider/supplier's participation in the Medicare program on the grounds that the provider/supplier no longer meets the conditions of participation/coverage, the contractor need not send a letter to the provider/supplier notifying the latter that its participation/enrollment in Medicare has been terminated. (The RO will issue such a letter and afford appeal rights.)	X		X	X	X					
6151.8	With respect to the list of transactions in section 5.6.3(B)(i) of chapter 10, the contractor shall make a recommendation for approval to the State/RO and await final approval from the RO before switching the PECOS record to "approved."	X			X						
6151.9	For those transactions identified in section 5.6.3(B)(ii) of chapter 10, the contractor shall notify the supplier via letter, e-mail, or telephone that the change has been made and shall switch the PECOS record to "approved."	X			X						
6151.9.1	In the situation described in 6151.9, the contractor shall notify the State and RO of the changed information (via any mechanism it chooses, including copying the State/RO on the notification letter or e-mail) no later than calendar 10 days after it has completed processing the transaction.	X			X						
6151.10	In situations where the supplier submits a: (1) CMS-855B reactivation, (2) CMS-855B revalidation, or (3) full CMS-855B as part of a change of information, the contractor shall make a recommendation to the State/RO and switch the record to "approval recommended" only if the application contains new/changed data falling within the category of items in section 5.6.3(B)(i), of chapter 10.	X			X						
6151.11	In situations where the supplier submits a: (1) CMS-	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	
	855B reactivation, (2) CMS-855B revalidation, or (3) full CMS-855B as part of a change of information, if the application contains new/changed data falling within the category of items in section 5.6.3(B)(ii), of chapter 10, the contractor shall switch the PECOS record to "approved" and notify the State/RO of the changed/new information (via any mechanism it chooses, including copying the State/RO on the notification letter or e-mail) no later than 10 calendar days after it has completed processing the transaction.										
6151.12	In cases where the provider's audit and claims intermediaries differ, the contractor shall not reject the provider's CMS-588 form if the provider listed the claims intermediary – rather than the audit intermediary – thereon.	X		X		X					
6151.13	When creating a PECOS enrollment record for one of the provider types identified in section 11.4 of chapter 10, the contractor shall select a Provider Type of "Other" and then enter the type of hospital in question.	X		X		X					
6151.14	The contractor shall note that if a supplier is enrolling as a group practice that is owned by a hospital (as opposed to being a hospital department), the contractor need not wait until the hospital's provider agreement is issued before conveying billing privileges to the group.	X			X						
6151.15	If a certified supplier's or provider's billing privileges are deactivated or reactivated, the contractor shall notify the RO thereof no later than 10 calendar days after the deactivation or reactivation becomes effective.	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.										

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	

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:

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.

4.4.2 – Section 4 of the CMS-855B

(Rev. 272; Issued: 11-07-08; Effective/Implementation Date: 12-08-08)

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

If the applicant's address or telephone number cannot be verified via Qualifier.net, the contractor shall contact the applicant for further information. If the supplier states that the facility or its phone number is not yet operational, the contractor shall continue processing the application. 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.

B. Reassignment of Benefits

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

C. Ambulance Companies

If an ambulance company will be furnishing all of its services in the same contractor jurisdiction, the supplier should list:

- *Each site at which its vehicles are garaged in section 4A.*
- *Each site from which its personnel are dispatched in section 4A.*
- *Its base of operations – which, for ambulance companies, is their primary headquarters – in section 4E.*

If the supplier will be furnishing services in more than one jurisdiction, it shall follow the applicable instructions in section 4.18 of this chapter.

5.5.2.3 - Processing CHOW Applications

(Rev. 272; Issued: 11-07-08; Effective/Implementation Date: 12-08-08)

Unless stated otherwise in this *chapter*, the intermediary shall ensure that all applicable sections of the CMS-855A for both the old and new owners are completed in accordance with the instructions on the CMS-855A.

A. Old Owners

The old owner's CMS-855A CHOW application does not require a recommendation for approval or denial; any recommendations will be based upon the CHOW application received from the new owner.

If the old owner's CMS-855A is available at the time of review, the intermediary shall examine the information thereon against the new owner's CMS-855A to ensure consistency (e.g., same names). If the old owner's CMS-855A has not been received, the intermediary shall contact the old owner and request it. However, the intermediary may begin processing the new owner's application without waiting for the arrival of the old owner's application; it may also make its recommendation to the State agency without having received the old owner's CMS-855A. The intermediary, of course, shall not make a recommendation for approval unless the new owner has checked on the form that it will assume the provider agreement and that the terms of the sales agreement indicate as such.

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

Note that an old owner's CMS-855A CHOW application is essentially the equivalent of a CMS-855 voluntary termination submission, as the seller is voluntarily leaving the Medicare program. As such, the contractor shall not require the seller to submit a separate CMS-855 voluntary termination along with its CMS-855A CHOW application.

B. New Owners

If a CMS-855A is not received from the new owner within 14 calendar days of receipt of the old owner's CMS-855A, the intermediary shall contact the new owner. If the new owner fails to: (1) submit a CMS-855A and (2) indicate that it accepts assignment of the provider agreement, within 30 calendar days after the intermediary contacted it, the latter shall stop payments unless the sale has not yet taken place per the terms of the sales agreement. Payments to the provider can resume once this information is received and the intermediary ascertains that the provider accepts assignment.

C. Order of Processing

To the maximum extent practicable, CMS-855A applications from the old and new owners in a CHOW should be processed as they come in. The intermediary should not wait for applications from both the old and new owner to arrive before processing them. However, unless the instructions in this *chapter* indicate otherwise, the intermediary should attempt to send the old and new applications to the State simultaneously, rather than as soon as they are processed. For instance, suppose the old owner submits an application on March 1. The intermediary should begin processing the application immediately, without waiting for the arrival of the new owner's application. Yet it should avoid sending the old owner's application to the State until the new owner's

application comes in. (For acquisition/mergers and consolidations, the intermediary may send in the applications separately, since one number is going away.)

D. Sales Agreements

The intermediary shall abide by the following:

- **Verification of Terms** - The intermediary shall determine: (1) whether the information contained in the sales agreement is consistent with that reported on the new owner's CMS-855A (e.g., same names), and (2) whether the terms of the contract indicate that the new owner will assume the provider agreement. In many cases, the sales agreement will not specifically refer to the Medicare provider agreement. Clearly, if the box in section 2F is checked "yes" and the sales agreement either confirms that the new owner will assume the agreement or is relatively silent on the matter, the intermediary can proceed as normal. (The RO will obviously make the final decision.) Conversely, if the agreement indicates that the assets and liabilities will not be accepted, the contractor should recommend denial. As discussed above, such matters can be referred to the RO if needed.

- **Form of Sales Agreement** - There may be instances where the parties in a CHOW did not sign a "sales agreement" in the conventional sense of the term; the parties, for example, may have documented their agreement via a "bill of sale." The contractor may accept this alternative documentation in lieu of a sales agreement so long as the document furnishes clear verification of the terms of the transaction.

- **Submission of Final Sales Agreement** - The intermediary shall not forward a copy of the application to the State agency until it has received and reviewed the final sales agreement. It need not revalidate the information on the CMS-855A even if the data therein may be somewhat outdated by the time the final sales agreement is received.

  If a final sales agreement is not submitted within 90 days after the intermediary's receipt of the new owner's application, the intermediary shall reject the application. Though the intermediary must wait until the 90th day to reject the application, the intermediary may do so regardless of how many times it contacted the new owner or what type of responses (short of the actual receipt of the sales agreement) were obtained.

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

E. CHOWs Involving Subunits and Subtypes

Any subunit that has a separate provider agreement (e.g., HHA subunits) must report its CHOW on a separate CMS-855A. They cannot report the CHOW via the main provider's CMS-855A. If the subunit has a separate CCN number but not a separate provider agreement (e.g., hospital psychiatric unit, HHA branch), the CHOW can be disclosed on the main provider's CMS-855A. This is because the subunit is a practice location of the main provider and not a separately enrolled entity.

On occasion, a CHOW may occur in conjunction with a change to the facility's provider subtype. This most frequently happens when a hospital undergoes a CHOW and changes from a general hospital to another type of hospital, such as a psychiatric hospital. Although a change in hospital type is considered a change of information, it is not necessary for the provider to submit separate applications – one for the COI and one for the CHOW. Instead, all information (including the change of hospital type) should be reported on the CHOW application; the entire application should then be processed as a CHOW. However, if the facility is changing from one main provider type to another (e.g., hospital converting to a SNF) and also undergoing a CHOW, the provider must submit its application as an initial enrollment.

NOTE: For Medicare purposes, a critical access hospital (CAH) is a separately-recognized provider type. Thus, a general hospital that undergoes a CHOW while converting to a CAH must submit its CMS-855A as an initial enrollment, not as a CHOW.

F. Early Submission of CHOW Application

The CMS-855A CHOW applications may be accepted by the intermediary up to 90 calendar days prior to the anticipated date of the proposed ownership change. Any application received more than 3 months in advance of the projected sale date can be returned under section 3.2 of this *chapter*.

G. Unreported CHOW

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

If the contractor learns of the transaction via the receipt of a tie-in notice from the RO, it shall follow the instructions under "Receipt of Tie-In When CMS-855A Not Completed" in section 5.5.3*E* of this *chapter*.

H. Relocation of Entity

A new owner may propose to relocate the provider concurrent with the CHOW. If the relocation is to a site in a different geographic area serving different clients than previously served and employing different personnel to serve those clients, the contractor shall notify the RO immediately. Unless the RO dictates otherwise, the provider shall - per Pub. 100-07, chapter 3, section 3210.1(B)(5), treat the transaction as an initial enrollment (and the provider as a new applicant), rather than as an address change of the existing provider.

5.5.3 - Tie-In Notices

(Rev. 272; Issued: 11-07-08; Effective/Implementation Date: 12-08-08)

A. General Principles for Tie-In/Tie-out Issuances

Tie-in and tie-out notices *(CMS-2007)* are generally issued in the following circumstances:

1. Initial enrollments;

2. CHOWs;

3. Voluntary terminations;

4. Involuntary terminations (e.g., provider no longer meets conditions of participation or coverage) prompted by the State/RO

With the exception of voluntary and involuntary terminations, each of the transactions described above require a referral and recommendation to the State/RO.

B. CMS-855 Changes of Information

(i). Referrals to State/RO

The following is a list of CMS-855A changes of information that require a recommendation and referral to the State/RO:

- *Addition of OPT extension site;*
- *Addition of hospice satellite*
- *Addition of HHA branch;*
- *Change in type of PPS-exempt unit;*
- *Conversion of a hospital from one type to another (e.g., acute care to psychiatric);*

- *Change in practice location or subunit address in cases where a survey of the new site is required;*
- *Stock transfers*

In these situations, the PECOS record should not be switched to "approved" until the contractor receives notice from the RO that the latter has indeed authorized the change/addition.

(ii). Post-Approval RO Contact Required

Changes that do not mandate a recommendation to the State/RO but do require post-approval correspondence with the RO include:

- *Deletions/Voluntary Terminations of practice locations or subunits;*
- *LBN, TIN, or DBA name changes that do not involve a CHOW;*
- *Address changes that do not require a survey of the new location;*
- *Addition of hospital practice location*

For these transactions, the contractor shall notify the provider via letter, e-mail, or telephone that the change has been made and shall switch the PECOS record to "approved." The contractor shall also notify the State and RO of the changed information (via any mechanism it chooses, including copying the State/RO on the notification letter or e-mail) no later than 10 calendar days after it has completed processing the transaction. Such notice to the State/RO should specify the type information that is changing.

(iii). All Other Changes of Information

For all CMS-855A change requests not identified in (B)(i) or (B)(ii) above, the contractor shall notify the provider via letter, e-mail, or telephone that the change has been made and shall switch the PECOS record to "approved." The State and RO need not be notified of the change.

(iv). Revalidations, Reactivations and Complete CMS-855 Applications

In situations where the provider submits a: (1) CMS-855A reactivation, (2) CMS-855A revalidation, or (3) full CMS-855A as part of a change of information (i.e., the provider does not have a complete enrollment record in PECOS), the contractor shall make a recommendation to the State/RO and switch the PECOS record to "approval recommended" only if the application contains new/changed data falling within the category of items in (B)(i) above. For instance, if a revalidation application reveals a new hospital psychiatric unit that has never been previously reported to CMS via the CMS-855A, the contractor shall make a recommendation to the State/RO and await the

RO's approval before switching the record to "approved." In this situation, the contractor should forward the whole application to the State with a note explaining that the only matter the State/RO needs to consider is the new hospital unit.

If the application contains new/changed data falling within the category of items in (B)(ii) above, the contractor can switch the PECOS record to "approved." It shall also notify the State and RO of the changed information (via any mechanism it chooses, including copying the State/RO on the notification letter or e-mail) no later than 10 calendar days after it has completed processing the transaction.

C. Provider-Specific, Non-CMS-855 Changes

If the contractor receives a tie-in notice for a transaction/change regarding information that is not collected on the CMS-855 application, the contractor obviously need not request the provider to submit a CMS-855 change of information.

D. Involuntary Termination Prompted by State/RO

If the contractor receives a tie-out notice from the RO that involuntarily terminates the provider's participation in the Medicare program on the grounds that the provider no longer meets the conditions of participation, the contractor need not send a letter to the provider notifying the latter that its participation/enrollment in Medicare has been terminated. (The RO will issue such a letter and afford appeal rights.)

E. Miscellaneous Information

Items 1 through 6 below address special procedures related to the contractor's handling of tie-in and tie-out notices.

1. **Receipt of Tie-In When CMS-855A Not Completed** - If the contractor receives a tie-in notice from the RO but the provider never completed the necessary CMS-855A paperwork, the contractor shall have the provider complete and submit said paperwork. *This* applies to initial applications, CHOWs, practice location additions, etc.*, but does not apply to the cases described in subsection C above.*

2. Delegation to State Agency – *There may* be instances when the RO delegates the task of issuing tie-in or tie-out notices to the State agency. The *contractor* may accept such notices from the State in lieu of those from the RO. However, the *contractor* should first contact the applicable RO to confirm: (1) that the latter has indeed delegated this function to the State, and (2) the specific transactions (e.g., CHOWs, HHA branch additions) for which this function has been delegated.

3. **Review for Consistency** - When the contractor receives a tie-in notice or approval letter from the RO, it shall review its contents to ensure that the data on the notice/letter matches that on the CMS-855*A*. If there are discrepancies (e.g., different legal business

name, address), the *contractor shall contact* the applicable RO to determine why the data is different.

4. **Creation of New L & T Record Unnecessary** - The *contractor* is not required to create a new L & T record in PECOS when the tie-in notice comes in, as the existing record should not be in a final status and can therefore be modified. Simply changing the L & T status is sufficient.

5. Provider Inquiries – *Once the contractor has made its recommendation for approval to the State/RO, any inquiry the contractor receives from the provider regarding the status of its request for Medicare participation shall be referred to the State or RO.*

6. Timeframes - *So as not to keep the PECOS record in "approval recommended" status interminably, if the contractor does not receive notification of approval from the RO after what it deems to be an excessive amount of time, it may contact the RO to see if such approval is forthcoming.*

5.5.5 - State Surveys and the CMS-855A

(Rev. 272; Issued: 11-07-08; Effective/Implementation Date: 12-08-08)

In general, information on the CMS-855A is still considered to be valid notwithstanding a delay in the State survey. However, the provider will be required to submit an updated CMS-855A application to the contractor if:

- The contractor becomes aware of such a delay;
- The delay is the fault of the provider; and
- At least 6 months have passed since the contractor sent its recommendation for approval to the State.

If these criteria are met, the contractor shall send a letter to the provider requesting an updated CMS-855A. The application must contain, at a minimum, any information that is new or has changed since the recommendation for approval was made, as well as a newly-signed certification statement. If no information has changed, the provider may instead submit: (1) a letter on its business letterhead stating as such, and (2) a newly-signed CMS-855A certification statement.

NOTE: If the applicant is an HHA, it must resubmit capitalization data as required by section 12 of the CMS-855A irrespective of whether any of the provider's other CMS-855A information has changed. To illustrate, if no CMS-855A data has changed, the HHA must submit the letter, capitalization data and the signed certification statement.

If the provider fails to furnish the requested information within 60 days, the contractor shall submit a revised letter to the State that recommends denial of the provider's application.

5.6.3 - ASC/PXRS Tie-in Notices

(Rev. 272; Issued: 11-07-08; Effective/Implementation Date: 12-08-08)

(For purposes of this section 5.6.3, the terms "tie-in notices" and approval letters will be collectively referred to as tie-in notices. "Tie-out notices" are notices from the RO to the contractor that, in effect, state that the supplier's billing number, Medicare enrollment, practice location, etc., should be terminated.)

A. General Principles for Tie-in/Tie-out Issuances

*T*ie-in and tie-out notices are generally issued in the following circumstances:

1. Initial enrollments;

2. CHOWs;

3. Voluntary terminations;

4. Involuntary terminations (e.g., supplier no longer meets conditions of coverage) prompted by the State/RO.

With the exception of voluntary and involuntary terminations, each of the transactions described above require a referral and recommendation to the State/RO.

B. CMS-855B Changes of Information

(i). Referrals to State/RO

The following is a list of transactions that require a recommendation and referral to the State/RO:

- *Addition of practice location;*

- *Stock transfers;*

- *Change in practice location or subunit address in cases where a survey of the new site is required*

In these situations, the PECOS record should not be switched to "approved" until the contractor receives notice from the RO that the latter has indeed authorized the change/addition.

(ii). Post-Approval RO Contact Required

Changes that do not mandate a recommendation to the State/RO but do require post-approval correspondence with the RO include:

- *Deletions/voluntary terminations of practice locations or subunits;*
- *LBN, TIN, or DBA name changes that do not involve a CHOW;*

- *Address changes that do not require a survey of the new location;*

For these transactions, the contractor shall notify the supplier via letter, e-mail, or telephone that the change has been made and shall switch the PECOS record to "approved." The contractor shall also notify the State and RO of the changed information (via any mechanism it chooses, including copying the State/RO on the notification letter or e-mail) no later than 10 calendar days after it has completed processing the transaction. Such notice to the State/RO should specify the type of information that is changing.

(iii). All Other Changes of Information

For all CMS-855B change requests not identified in (i) or (ii) above, the contractor shall notify the supplier via letter, e-mail, or telephone that the change has been made and shall switch the PECOS record to "approved." The State and RO need not be notified of the change.

(iv). Revalidations, Reactivations and Complete CMS-855 Applications

In situations where the provider submits a: (1) CMS-855B reactivation, (2) CMS-855B revalidation, or (3) full CMS-855B as part of a change of information (i.e., the supplier does not have a complete enrollment record in PECOS), the contractor shall make a recommendation to the State/RO and switch the record to "approval recommended" only if the application contains new/changed data falling within the category of items in (i) above. For instance, if a revalidation application reveals a new practice location that has never been previously reported to CMS via the CMS-855B, the contractor shall make a recommendation to the State/RO and await the RO's approval before switching the record to "approved." In this situation, the contractor should forward the whole application to the State with a note explaining that the only matter the State/RO needs to consider is the new location.

If the application contains changed data falling within the category of items in (ii) above, the contractor can switch the PECOS record to "approved." The contractor shall also notify the State and RO of the changed information (via any mechanism it chooses, including copying the State/RO on the notification letter or e-mail) no later than 10 days after it has completed processing the transaction.

C. Supplier-Specific, Non-CMS-855 Changes

If the contractor receives a tie-in notice for a transaction/change regarding information that is not collected on the CMS-855B application, the contractor obviously need not request the supplier to submit a CMS-855B change of information.

D. Involuntary Termination Prompted by State/RO

If the contractor receives a tie-out notice from the RO that involuntarily terminates the supplier's participation in the Medicare program on the grounds that the supplier no longer meets the conditions of coverage, the contractor need not send a letter to the supplier notifying the latter that its participation/enrollment in Medicare has been terminated. The RO will issue such a letter and afford appeal rights.

E. Miscellaneous Information

Items 1 through 6 below address special procedures related to the contractor's handling of tie-in and tie-out notices.

1. **Receipt of Tie-In When CMS-855B Not Completed** - If the contractor receives a tie-in notice from the RO but the supplier never completed the necessary CMS-855B paperwork, the contractor shall have the supplier complete and submit said paperwork. This applies to initial applications, CHOWs, practice location additions, etc., *but does not apply to the cases described in subsection C above.*

2. Delegation to State Agency – *There may be* instances when the RO delegates the task of issuing tie-in or tie-out notices to the State agency. The contractor may accept such notices from the State in lieu of those from the RO. However, the contractor should first contact the applicable RO to confirm: (1) that the latter has indeed delegated this function to the State, and (2) the specific transactions (e.g., CHOWs, site additions) for which this function has been delegated.

3. **Review for Consistency** - When the contractor receives a tie-in notice *or approval letter* from the RO, it shall review its contents to ensure that the data on the notice/letter matches that on the CMS-855B. If there are discrepancies (e.g., different legal business name, address), the contractor shall *contact the applicable RO to* determine why the data is different.

4. **Creation of New L & T Record Unnecessary** - The contractor is not required to create a new L & T record in PECOS when the tie-in notice comes in, as the existing record should not be in a final status and can therefore be modified. Simply changing the L & T status is sufficient.

5. Provider Inquiries - *Once the contractor has made its recommendation for approval to the State/RO, any inquiry the contractor receives from the provider regarding the status of its request for Medicare participation shall be referred to the State or RO.*

6. Timeframes - *So as not to keep the PECOS record in "approval recommended" status interminably, if the contractor does not receive notification of approval from the RO after what it deems to be an excessive amount of time, it may contact the RO to see if such approval is forthcoming.*

5.6.5 - State Surveys and the CMS-855B

(Rev. 272; Issued: 11-07-08; Effective/Implementation Date: 12-08-08)

A. *Delay in State Survey*

In general, information on the CMS-855B is still considered to be valid notwithstanding a delay in the State survey. However, the supplier will be required to submit an updated CMS-855B application to the contractor if:

- The contractor becomes aware of such a delay;
- The delay is the fault of the supplier; and
- At least 6 months have passed since the contractor sent its recommendation for approval to the State.

If these criteria are met, the contractor shall send a letter to the supplier requesting an updated CMS-855B. The application must contain, at a minimum, any information that is new or has changed since the recommendation for approval was made, as well as a newly-signed certification statement. If no information has changed, the supplier may instead submit: (1) a letter on its business letterhead stating as such, and (2) a newly-signed CMS-855*B* certification statement.

If the supplier fails to furnish the requested information within 60 calendar days, the contractor shall submit a revised letter to the State that recommends denial of the supplier's application.

B. Future Effective Dates

In situations where the contractor cannot enter effective dates into PECOS because the supplier, its practice location, etc., is not yet established, the contractor may use the authorized official's date of signature as the temporary effective date. Once the provider and actual effective date is established (e.g., the tie-in notice is received), the contractor shall go into PECOS and change the effective date.

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

(Rev. 272; Issued: 11-07-08; Effective/Implementation Date: 12-08-08)

A. **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.

B. 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.

C. 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.

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

(Rev. 272; Issued: 11-07-08; Effective/Implementation Date: 12-08-08)

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.

When creating a PECOS enrollment record for one of these providers, the contractor shall select a Provider Type of "Other" and then enter the type of hospital in question.

11.5 – Carrier Processing of Hospital Applications

(Rev. 272; Issued: 11-07-08; Effective/Implementation Date: 12-08-08)

A. Group Practices

The carrier shall review all CMS-855B applications for hospital-owned clinics/physician practices and department billings. The carrier shall contact the applicant to determine if the latter will be billing any of these locations as provider-based. If the applicant will not be billing as provider-based, the carrier shall process the application normally. If, however, the applicant will bill as provider-based, the carrier shall notify the applicant that the hospital must report any changed practice locations to its intermediary via the CMS-855A.

If the supplier is enrolling as a hospital department (under the "Clinic/Group Practice" category on the CMS-855B) or an existing hospital department is undergoing a change of ownership (CHOW), the *contractor* shall only issue the necessary billing numbers upon notification that a provider agreement has been issued *– or, in the case of a CHOW,* the provider agreement has been transferred to the new owner. *If, however, the supplier is enrolling as a group practice that is merely owned by a hospital (as opposed to being a hospital department), it is not necessary for the contractor to wait until the provider agreement is issued before conveying billing privileges to the group.*

B. Individual Billings

Assume an individual physician works for a hospital and will be billing for services as an individual (i.e., not as part of the hospital service/payment). However, he/she wants to reassign these benefits to the hospital. In this case, the hospital needs to enroll with the *contractor* via the CMS-855B (e.g., as a hospital department, outpatient location).

13.1 – CMS or Contractor Issued Deactivations

(Rev. 272; Issued: 11-07-08; Effective/Implementation Date: 12-08-08)

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 to its designated DPSE contractor liaison *no later than the last calendar day of each month.*

B. Certified Suppliers and Providers

If a certified supplier's or provider's billing privileges are deactivated or reactivated, the contractor shall notify the RO thereof no later than 10 calendar days after the deactivation or reactivation became effective. The notification can be done in any manner the contractor chooses, including copying the RO on any reactivation/deactivation letter sent to the supplier or provider.