CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 711	**Date: April 25, 2017**
	Change Request 9953

Transmittal 710, dated April 14, 2017, is being rescinded and replaced by Transmittal 711, dated April 25, 2017 2017, to remove section 15.4.1.4 (Federally Qualified Health Centers (FQHCs)) from the list of manual revisions in Section II (Changes in Manual Instructions) of the transmittal and add section 15.4.6.1 (Diabetes Self-Management Training (DSMT)). All other information remains the same.

SUBJECT: Update to Pub. 100-08, Chapter 15

I. SUMMARY OF CHANGES: The purpose of this change request (CR) is to make several revisions to Chapter 15 of Pub. 100-08.

EFFECTIVE DATE: May 15, 2017
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: May 15, 2017

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

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	15/15.4/15.4.6.1/Diabetes Self-Management Training (DSMT)
R	15/15.5/15.5.4.3/Section 4 of the Form CMS-855I
R	15/15.5/15.5.14.4/Submission of Paper and Internet-based PECOS Certification Statements
R	15/15.5/15.5.20/Processing Form CMS-855R Applications
R	15/15.7/15.7.7.1.5/Electronic Funds Transfer (EFT) Payments and CHOWs
R	15/15.7/15.7.7.2/Tie-In/Tie-Out Notices and Referrals to the State/RO
R	15/15.7/15.7.8.4/Ambulatory Surgical Centers (ASCs)/Portable X-ray Suppliers (PXRS) Tie-In/Tie-Out Notices and Referrals to the State/RO
R	15/15.23/15.23.2/Release of Information
R	15/15.23/15.23.3/File Maintenance
R	15/15.24/15.24.7/Approval Letter Guidance
R	15/15.24/15.24.7.1/Model Approval Letter
R	15/15.24/15.24.8.6/Denial Example #5 – Existing or Delinquent Overpayments

III. FUNDING:

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

Attachment - Business Requirements

Pub. 100-08	Transmittal: 711	Date: April 25, 2017	Change Request: 9953

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SUBJECT: Update to Pub. 100-08, Chapter 15

EFFECTIVE DATE: May 15, 2017
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: May 15, 2017

I. GENERAL INFORMATION

A. Background: This CR is intended to update general information for provider enrollment regarding payment arrangements for new and old owners undergoing a change of ownership (CHOW), site visit requirements for providers that render services solely in patient's homes, process to follow when the Regional Office (RO) issues a tie-out notice to involuntary terminate a provider, file maintenance requirements and clarification of certification statement signature requirements.

B. Policy: This CR does not involve any legislative or regulatory policies.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
9953.1	If a person or entity enrolls to provide Diabetes self-management training services and that provider type requires the submission of an application fee, contractors shall require that the fee be submitted with the application.		X							
9953.2	Contractors shall not request a site visit if the physician or non-physician practitioner indicates on the CMS-855 application that he/she uses a home address as the practice location and exclusively performs services in patients' homes.		X							
9953.3	For paper and web applications that require development,	X	X	X						NSC

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	contractors shall only require the dated signature of at least one of the provider's authorized officials or delegated officials be on the certification statement; obtaining the signatures of the other authorized and delegated officials is not required.									
9953.4	For Internet-based Provider Enrollment, Chain and Ownership System (PECOS) submissions, if the provider mails in the signed certification statement, but fails to electronically submit the web application, contractors should contact the provider and request the provider fully submit the application in PECOS. The date of receipt shall be the date the application and all required signatures have been received.	X	X	X						NSC
9953.5	Contractors shall not permit the Seller/Transferor to bill for services after CHOW processing is complete. After CHOW processing is complete the Seller/Transferor will no longer be allowed to bill for services (i.e., services furnished after CHOW processing is complete) and only the Buyer is permitted to submit claims using the existing CMS Certification Number. It is ultimately the responsibility of the old and new owners to work out between themselves any payment arrangements for claims for services furnished during the CHOW processing period.	X		X						
9953.6	Upon receipt of a tie-out notice from the RO that involuntary terminates a provider's Medicare participation, contractors shall adhere to the	X	X	X						

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	instructions in section 15.27.2 of Pub. 100-08 with respect to revoking the provider's/supplier's enrollment, as the supplier is no longer in compliance with Medicare enrollment regulations.									
9953.6.1	Contractors shall record the revocation in PECOS using the status reason of "Non-Compliance: Provider/Supplier Type Requirements Not Met."	X	X	X						
9953.6.2	Contractors shall not identify the involuntary termination action in PECOS as a Deactivation with a status reason of "Voluntarily Withdrawal from the Medicare Program."	X	X	X						
9953.6.3	Contractors shall enter the appropriate enrollment bar and issue a revocation letter to the certified provider or supplier using 42 CFR §424.535(a)(1), as the legal basis for the revocation. The letter shall also contain the effective date of the revocation, appeal rights and the length of the enrollment bar.	X	X	X						
9953.6.4	Contractors should not contact the RO to obtain details of the termination. The issuance of the Tie-Out for non-compliance of CMS enrollment requirements, conditions of participation, or conditions of coverage is sufficient to revoke.	X	X	X						
9953.7	Contractors shall include in their provider files, copies of any documentation found on the Medicare Exclusion Database report that leads to a provider's or supplier's	X	X	X						NSC

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	revocation.									
9953.8	Contractors shall include in their change of information approval letters the elements that were changes along with the effective dates of the changed information.	X	X	X						NSC
9953.8.1	The effective date of the changed information shall be either the date of addition, change, or deletion specified on the associated application or the date of receipt of the associated application.	X	X	X						NSC
9953.9	Contractors shall include in their approval letters the retrospective billing date, if different than the effective date.		X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): Joe Schultz, 410-786-2656 or Joseph.Schultz@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: 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.

ATTACHMENTS: 0

15.4.6.1 - Diabetes Self-Management Training (DSMT)

(Rev.711 Issued: 04-25-17, Effective: 05-15-17 Implementation: 05-15-17)

A. Background

Diabetes self-management training (DSMT) is not a separately recognized provider type, such as a physician or nurse practitioner. A person or entity cannot enroll in Medicare for the sole purpose of performing DSMT. Rather, DSMT is an extra service that an enrolled provider or supplier can bill for, assuming it meets all of the necessary DSMT requirements. *If the person or entity enrolls as a provider type (i.e., pharmacy, mass immunizer) that requires the submission of an application fee, the fee shall be submitted with the application.*

All DSMT programs must be accredited as meeting quality standards by a CMS-approved national accreditation organization. Currently, CMS recognizes the American Diabetes Association (ADA) and the American Association of Diabetes Educators (AADE) as approved national accreditation organizations. A Medicare-enrolled provider or non-DMEPOS supplier that wishes to bill for DSMT may simply submit the appropriate accreditation certificate to its contractor. No Form CMS-855 is required, unless the provider or supplier is not in the Provider Enrollment, Chain and Ownership System (PECOS), in which case a complete Form CMS-855 application must be submitted.

If the supplier is exclusively a DMEPOS supplier, it must complete and submit a Form CMS-855B application to its local Part A/B Medicare Administrative Contractor (A/B MAC). This is because A/B MACs, rather than Durable Medical Equipment Medicare Administrative Contractors, pay DSMT claims. Thus, the DMEPOS supplier must separately enroll with its A/B MAC, even if it has already completed a Form CMS-855S. If an A/B MAC receives an application from a DMEPOS supplier that would like to bill for DMST, it shall verify with the National Supplier Clearinghouse that the applicant is currently enrolled and eligible to bill the Medicare program.

For more information on DSMT, refer to:

- 42 CFR Part 410 (subpart H)
- Publication 100-02, Medicare Benefit Policy Manual, chapter 15, sections 300 – 300.5.1

15.5.4.3 – Section 4 of the Form CMS-855I

(Rev.711 Issued: 04-25-17, Effective: 05-15-17 Implementation: 05-15-17)

A. Solely-Owned Organizations

The former practice of having solely-owned practitioner organizations (as explained and defined in section 4A of the CMS-855I) complete a CMS-855B, a CMS-855R, and a CMS-855I has been discontinued. All pertinent data for these organizations can be furnished via the CMS-855I alone. The contractor, however, shall require the supplier to submit a CMS-855B, CMS-855I and CMS-855R if, during the verification process, it discovers that the supplier is not a solely-owned organization. (**NOTE**: A solely-owned supplier type that normally completes the CMS-855B to enroll in Medicare must still do so. For example, a solely-owned LLC that is an ambulance company must complete the CMS-855B, even though section 4A makes mention of solely-owned LLCs. Use of section 4A of CMS-855I is limited to suppliers that perform physician or practitioner services.)

Sole proprietorships need not complete section 4A of the CMS-855I. By definition, a sole proprietorship is not a corporation, professional association, etc. Do not confuse a sole proprietor with a physician whose business is that of a corporation, LLC, etc., of which he/she is the sole owner.

In section 4A, the supplier may list a type of business organization other than a professional corporation, a professional association, or a limited liability company (e.g., closely-held corporation). This is acceptable so long as that business type is recognized by the State in which the supplier is located.

The contractor shall verify all data furnished in section 4A (e.g., legal business name, TIN, adverse legal actions). If section 4A is left blank, the contractor may assume that it does not pertain to the applicant.

A solely-owned physician or practitioner organization that utilizes section 4A to enroll in Medicare can generally submit change of information requests to Medicare via the CMS-855I. However, if the change involves data not captured on the CMS-855I, the change must be made on the applicable CMS form (i.e., CMS-855B, CMS-855R).

B. Individual Affiliations

If the applicant indicates that he/she intends to render all or part of his/her services in a group setting, the contractor shall ensure that the applicant (or the group) has submitted a CMS-855R for each group to which the individual plans to reassign benefits. The contractor shall also verify that the group is enrolled in Medicare. If it is not, the contractor shall enroll the group prior to approving the reassignment.

C. Practice Location Information

A practitioner who only renders services in patients' homes (i.e., house calls) must supply his/her home address in section 4C. In addition, if a practitioner renders services in a retirement or assisted living community, section 4C must include the name and address of that community. In either case, the contractor shall verify that the address is a physical address. Post office boxes and drop boxes are not acceptable.

> *If the physician or non-physician practitioner uses his/her home address as their practice location and exclusively performs services in patients' homes, nursing homes, etc., no site visit is necessary.*

D. Sole Proprietor Use of EIN

The practitioner must obtain a separate EIN if he/she wants to receive reassigned benefits as a sole proprietor.

E. NPI Information for Groups

If a supplier group/organization is already established in PECOS (i.e., status of "approved), the physician or non-physician practitioner is not required to submit the NPI in 4B2 of the 855I. In short, if group/organization is already established in PECOS, the group/organization does not need to include an NPI in section 4B2. The only NPI that the physician or non-physician practitioner must supply is the NPI found in section 4C.

NOTE: Physicians and non-physician practitioners are required to supply the NPI in section 4B2 of the CMS-855I for groups/organizations not established in PECOS with a status of "approved."

F. Out-of-State Practice Locations

If a supplier is adding a practice location in another State, a separate, initial Form CMS-855I enrollment application is required for that location even if:

- The location is part of the same organization (e.g., a solely-owned corporation),
- The location has the same tax identification number (TIN) and legal business name (LBN), and
- The location is in the same contractor jurisdiction.

To illustrate, suppose the contractor's jurisdiction consists of States X, Y and Z. Dr. Jones, a sole proprietor, is enrolled in State X with 2 locations. He wants to add a third location in State Y under his social security number and his sole proprietorship's employer identification number. A separate, initial Form CMS-855I application is required for the State Y location.

15.5.14.4 – Submission of Paper and Internet-based PECOS Certification Statements

(Rev.711 Issued: 04-25-17, Effective: 05-15-17 Implementation: 05-15-17)

A. Paper Submissions

A signed certification statement shall accompany the paper CMS-855 application. If the provider submits an invalid certification statement or fails to submit a certification statement, the contractor shall still proceed with processing the application. An appropriate certification statement shall be solicited as part of the development process – preferably via email or fax. This includes certification statements that are: (a) unsigned; (b) undated; (c) contains a copied or stamped signature; (d) was signed (as reflected by the date of signature) more than 120 days prior to the date on which the contractor received the application); (e) for paper Form CMS-855I and Form CMS-855O submissions, someone other than the physician or non-physician practitioner signed the form, except as noted in section 15.5.14.1; or (f) missing certification statements. The contractor shall send one development request to include a list of all of the missing required data/documentation, including the certification statement. The contractor may reject the provider's application if the provider fails to furnish the missing information on the enrollment application - including all necessary documentation - within 30 calendar days from the date the contractor requested the missing information or documentation. Unless stated otherwise in this chapter or in another CMS directive:

- The contractor shall use the development date that the 30-day clock expires as the date of signature. Once the above step is complete, the contractor shall: (1) enter the date of signature in the "Certification Date" box in the logging & tracking (L & T) record, and (2) change the L & T status to "In Review."

- The certification statement may be returned via scanned email, fax or mail to the contractor (as long as an original certification statement signature exist on file).

- Signature dates cannot be prior to 120 days of the receipt date of the application.

- *For paper applications that require development, it is only necessary that the dated signature of at least one of the provider's authorized or delegated officials be on the certification statement that must be sent in within 30 days; obtaining the signatures of the other authorized and delegated officials is not required.*

- For initial paper applications (as the term "initial" is defined in section 15.6.1 of this chapter), it is only necessary that the dated signature of at least one of the provider's authorized officials be on the certification statement that must be sent in within 30 days; obtaining the signatures of the other authorized and delegated officials is not required.

- For paper changes of information applications (as the term "changes of information" is defined in section 15.6.2 of this chapter), if the certification statement is signed by an individual who is not on file with the contractor as being an authorized or delegated official of the provider, the contractor may accept the certification statement but shall develop for information on the person in question in accordance with sections 15.5.14.3.1 and 15.5.14.3.2 of this chapter.

- The contractor is not required to compare the signature thereon with the same provider, authorized or delegated official's signature on file to ensure that it is the same person. The contractor shall not request the submission of a driver's license or passport to verify a signature.

B. Internet-based PECOS Submissions

If the provider submits its application online and chooses to submit its certification statement via paper rather than through e-signature, it may do so by email, fax or mail (as long as an original certification statement signature exist on file). Unless stated otherwise in this chapter or in another CMS directive:

- The contractor shall not begin processing the application prior to its receipt of the certification statement.

- The provider must submit the paper certification statement within 20 calendar days of the date on which it submitted its Internet-based PECOS application. (This applies to all Form CMS-855 Internet-based PECOS submissions, regardless of the type of transaction involved and applications where multiple signatures are required but not all have been submitted).

- • If the contractor does not receive the certification statement in its mailroom (or via email/fax or through e-signature) within the 20-day period, the contractor shall reject the L&T (unless another CMS directive states otherwise). The contractor is not required to develop (This applies to revalidation and non-revalidation submissions).

- Signature dates cannot be prior to 120 days of the receipt date of the application.

- If the provider submits an invalid certification statement, the contractor shall treat this as missing information and develop for a correct certification statement – preferably via email or fax. This includes certification statements that are: (a) unsigned; (b) undated; (c) contains a copied or stamped signature; (d) was signed (as reflected by the date of signature) more than 120 days prior to the date on which the contractor received the application); or (e) for paper Form CMS-855I and Form CMS-855O submissions, someone other than the physician or non-physician practitioner signed the form. The contractor shall send one development request to include a list of all of the missing required data/documentation, including the certification statement. The contractor may reject the provider's application if the provider fails to furnish the missing information on the enrollment application - including all necessary documentation - within 30 calendar days from the date the contractor requested the missing information or documentation.

- *For Internet-based PECOS applications that require development, it is only necessary that the dated signature of at least one of the provider's authorized or delegated officials be on the certification statement that must be sent in within 30 days; obtaining the signatures of the other authorized and delegated officials is not required.*

- For initial Internet-based PECOS applications (as the term "initial" is defined in section 15.6.1 of this chapter), it is only necessary that the dated signature of at least one of the provider's authorized officials be on the certification statement that must be sent in within 20 days; obtaining the signatures of the other authorized and delegated officials is not required.

- For Internet-based PECOS changes of information applications (as the term "changes of information" is defined in section 15.6.2 of this chapter), if the certification statement is signed by an individual who is not on file with the contractor as being an authorized or delegated official of the provider, the contractor may accept the certification statement but shall develop for information on the person in question in accordance with sections 15.5.14.3.1 and 15.5.14.3.2 of this chapter.

- If the application is submitted via Internet-based PECOS and the provider wishes to submit a paper CMS-855 certification statement (downloaded from www.cms.gov), it should write the tracking ID on the top of the certification statement. If the provider does not list the tracking ID number on the signature page, but the contractor is able to identify which application the signature belongs to, development is not required. If the contractor is not able to identify the application through research

or development due to missing contact information, the contractor shall return the signature page to the return address on the incoming envelope.

- The contractor is not required to compare the signature thereon with the same provider, authorized or delegated official's signature on file to ensure that it is the same person. The contractor shall not request the submission of a driver's license or passport to verify a signature.

- *For internet-based PECOS submissions, if the provider mails in their signed certification statement but fails to electronically submit their web application, the MAC shall contact the provider and request they fully submit the application in PECOS. The receipt date of application shall be the date the application and all required signatures have been received.*

15.5.20 – Processing Form CMS-855R Applications

(Rev.711 Issued: 04-25-17, Effective: 05-15-17 Implementation: 05-15-17)

A. General Information

A Form CMS-855R application must be completed for any individual who will: (1) reassign his/her benefits to an eligible entity, (2) terminate an existing reassignment, or (3) update the primary practice location listed on the Form CMS-855R. Separate Form CMS-855Rs must be completed for each transaction.

If the individual who wants to reassign his or her benefits is not enrolled in Medicare, the person must complete a Form CMS-855I as well as a Form CMS-855R. (The CMS-855I and CMS-855R can be submitted concurrently.) Moreover, if the entity to which the person's benefits will be reassigned is not enrolled in Medicare, the organization must complete a Form CMS-855B or, if applicable, a Form CMS-855A. (See section 15.7.6 for additional instructions regarding the joint processing of Form CMS-855As, Form CMS-855Rs, Form CMS-855Bs, and Form CMS-855Is.)

Benefits are reassigned to a provider or supplier, not to the practice location(s) of the provider or supplier. As such, the contractor shall not require each practitioner in a group to submit a Form CMS-855R each time the group adds a practice location.

An individual can receive reassigned benefits. The most common example of this is a physician or practitioner who reassigns his/her benefits to a physician who is either (1) a sole proprietor, or (2) the sole owner of an entity listed in section 4A of the Form CMS-855I. Here, the only forms that are necessary are the Form CMS-855R and separate Form CMS-855Is from the reassignor and the reassignee. (No Form CMS-855B or Form CMS-855A is involved.) The reassignee himself/herself must sign section 6B of the Form CMS-855R, as there is no authorized or delegated official involved.

The contractor shall follow the instructions in Pub. 100-04, chapter 1, sections 30.2 – 30.2.16 to ensure that a physician or other provider or supplier is eligible to receive reassigned benefits.

B. Reassignment to Entities that Complete the Form CMS-855A

Consistent with 42 CFR §424.80(b)(1) and (b)(2) and Pub. 100-04, chapter 1, sections 30.2.1(D) and (E) and 30.2.6 and 30.2.7, Medicare may pay: (1) a physician or other provider or supplier's employer if the provider or supplier is required, as a condition of employment, to turn over to the employer the fees for his or her services; or (2) an entity (i.e., a person, group, or facility) that is enrolled in the Medicare program for services furnished by a physician or other provider or supplier under a contractual arrangement with that entity. This means that Part A and Part B entities other than physician/practitioner group practices can receive reassigned benefits, assuming the requirements for a reassignment exception are met. For example, on the Part A side, this might occur with (1) a physician or other provider or supplier reassigning benefits to a hospital, skilled nursing facility, or critical access hospital billing under Method II (Critical Access Hospital (CAH) II) or (2) a nurse practitioner reassigning to a CAH II.

If the entity receiving the reassigned benefits is not a CAH II, it must enroll with the contractor via a Form CMS-855B, and the physician/practitioner reassigning benefits must complete and submit a Form CMS-855I and Form CMS-855R.

If the entity receiving the reassigned benefits is a CAH II, the entity need not and should not complete a separate Form CMS-855B form to receive reassigned benefits. The physician/practitioner can reassign benefits directly to the CAH II's Part A enrollment. The distinction between CAHs billing Method I vs. Method II only applies to outpatient services; it does not apply to inpatient services.

Under Method I:

- The CAH bills for facility services
- The physicians/practitioners bill separately for their professional services

Under Method II

- The CAH bills for facility services

- If a physician/practitioner has reassigned his/her benefits to the CAH, the CAH bills for that particular physician's/practitioner's professional service

- If a CAH has elected Method II, the physician/practitioner is not required to reassign his or her benefits to the CAH. For those physicians/practitioners who do not reassign their benefits to the CAH, the CAH only bills for facility services and the physicians/practitioners separately bill for their professional services (similar to Method I).

Although eligible physicians or non-physician practitioners are not required to reassign their benefits to a CAH that bills Method II, doing so allows them to participate in the Electronic Health Records (EHR) Incentive Program for Eligible Professionals (EPs).

In this scenario, the Forms CMS-855I and CMS-855R shall be submitted to the Part B MAC and the Form CMS-855A to the Part A MAC. The Part B MAC shall be responsible for reassigning the individual to the Part A entity.

The reassignment to the Part A entity shall only occur if the Form CMS-855A for the CAH II has been finalized. This can be determined by viewing PECOS to identify if an approved enrollment exists for the CAH II. If one does not, the Part B MAC shall return the Form CMS-855I and/or Form CMS-855R to the provider. If an enrollment record exist but is in an Approved Pending RO Review status, the Part B MAC shall contact the Part A MAC to determine if the tie-in notice has been received from the RO but not yet updated in PECOS, prior to returning the applications.

C. Ambulatory Surgical Centers (ASCs) and Reassignment

Physicians and non-physician practitioners who meet the reassignment exceptions in 42 CFR §424.80, and Pub. 100-04, chapter 1, sections 30.2.6 and 30.2.7, may reassign their benefits to an ASC.

If a physician or non-physician practitioner wishes to reassign its benefits to an existing (that is, a currently-enrolled) ASC, both the individual and the entity must sign the CMS-855R. However, it is not necessary for the ASC to separately enroll as a group practice in order to receive benefits. It can accept reassignment as an ASC.

D. Reassignment and Revoked/Deceased Physicians and Non-Physician Practitioners

There are situations where a physician/non-physician practitioner (the "owning physician/practitioner") owns 100% of his/her own practice, employs another physician (the "employed physician/practitioner") to

work with him/her, and accepts reassigned benefits from the employed physician/practitioner. Should the sole proprietor or sole owner die or have his/her billing privileges revoked, the practice is automatically dissolved for purposes of Medicare enrollment and all reassignments to the practice are automatically terminated as well. Neither the owning physician/practitioner nor the practice is enrolled in Medicare any longer and the enrollments for both shall be revoked in accordance with the revocation procedures outlined in this chapter. (It is immaterial whether the practice was established as a sole proprietorship, a professional corporation, a professional association, or a solely-owned limited liability company.) In addition, the contractor shall end-date the reassignment using, as applicable, the date of death or the effective date of the revocation.

Besides revoking the *enrollments* of the owning physician/practitioner and the practice, the contractor shall notify the employed physician/practitioner that:

(1) The practice's enrollments have been revoked;

(2) Any services furnished by him/her on behalf of the practice after the date of the owning physician/practitioner's death will not be paid; and

(3) If the employed physician/practitioner wishes to provide services at the former practice's location, he/she must submit via Internet-based PECOS (or a paper Form CMS-855 application) a Form CMS-855I change of information request to add the owning physician/practitioner's practice location as a new location of the employed physician/practitioner. For purposes of this section 15.5.20(C)(3) only, submission of a (1) complete Form CMS-855I application as an initial enrollment and (2) a terminating Form CMS-855R application are not required – even if the employed physician/non-physician practitioner had reassigned all of his/her benefits to the practice.

E. Miscellaneous Reassignment Policies

1. A Form CMS-855R is required to terminate a reassignment. The termination cannot be done via the Form CMS-855I (except for Internet-based PECOS applications when the termination is for the last PTAN on an enrollment).

2. The authorized or delegated official who signs section 6 of the Form CMS-855R must be currently on file with the contractor as such. If this is a new enrollment - with a joint submission of the Form(s) CMS-855A or CMS 855B, Form CMS-855I, and Form CMS-855R - the person must be listed on the CMS-855A or CMS-855B as an authorized or delegated official.

3. If the Form CMS-855R is accompanied by an initial Form CMS-855I or submitted as a "stand-alone" form (that is, a Form CMS-855R is submitted as a new reassignment, such as when an enrolled physician who is operating as a sole proprietor joins a group practice and reassigns his benefits to the group), the effective date of the enrollment and the reassignment shall be consistent with the 30-day rule (i.e., the later of the date of filing or the date the reassignor first began furnishing services at the new location) specified in section 15.17 of this chapter.

4. The contractor need not verify whether the reassigning individual is a W-2 employee or a 1099 contractor.

5. In situations where the provider or supplier is both adding and terminating a reassignment, each transaction must be reported on a separate Form CMS-855R. The same Form CMS-855R cannot be used for both transactions.

6. The Form CMS-855R application shall not be used to:

- Report employment arrangements of physician assistants (PAs); employment arrangements for PAs must be reported on the Form CMS-855I.

- Revalidate reassignments; the individual practitioner should only use the Form CMS-855I and list his or her active reassignment information in section 4B thereof.

- Go to *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019033.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending* to view the CMS-855R Processing Guide, which constitutes a general Form CMS-855R processing guide for providers/suppliers and contractors. The procedures described in the Guide, which include processing alternatives and processing instructions for the Form CMS-855R, take precedence over all other instructions in this chapter concerning the processing of Form CMS-855R applications.

15.7.7.1.5 – Electronic Funds Transfer (EFT) Payments and CHOWs

(Rev.711 Issued: 04-25-17, Effective: 05-15-17 Implementation: 05-15-17)

In a CHOW, the contractor shall continue to pay the Seller/Transferor until it receives the tie-in/approval notice from the RO. Hence, the contractor shall reject any application from the Seller or the Buyer to change the EFT account or special payment address to that of the new owner before receiving the tie-in/approval notice. It is ultimately the responsibility of the Buyer and the Seller to work out any payment arrangements between themselves while the contractor and RO are processing the CHOW. It is advisable that the contractor notify the new owner of this while the application is being processed.

In a CHOW, the existing provider agreement is automatically assigned to the Buyer/Transferee. If the Buyer/Transferee does not explicitly reject automatic assignment before the transfer date, the provider agreement is automatically assigned, along with the CCN, effective on the transfer date. The assigned agreement is subject to all applicable statutes and regulations and to the terms and conditions under which it was originally issued. Among other things, this means that the contractor will continue to adjust payments to the provider to account for prior overpayments and underpayments, even if they relate to services provided before the sale/transfer. If the Buyer rejects assignment of the provider agreement, the Buyer must file an initial application to participate in the Medicare program. In this situation, Medicare will ***never*** *pay the applicant for services the prospective provides before the date on which the provider qualifies for Medicare participation as an initial applicant.*

Depending on the terms of the sale, the Buyer/Transferee may obtain a new NPI or maintain the existing NPI. After CHOW processing is complete, the Seller/Transferor will no longer be allowed to bill for services (i.e., services furnished after CHOW processing is complete) and only the Buyer is permitted to submit claims using the existing CCN. It is ultimately the responsibility of the old and new owners to work out between themselves any payment arrangements for claims for services furnished during the CHOW processing period.

15.7.7.2 - Tie-In/Tie-Out Notices and Referrals to the State/RO

(Rev.711 Issued: 04-25-17, Effective: 05-15-17 Implementation: 05-15-17)

A. Issuance of Tie-In/Tie-Out Notices

A tie-in or tie-out notice (CMS-2007) is 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 requires a referral and recommendation to the state/RO.

(Depending on the specific RO, certain changes of information may also result in the issuance of a CMS-2007.)

B. Form CMS-855 Changes of Information, Stock Transfers, and Other Transactions

1. Referrals to State/RO

The following is a list of Form CMS-855A transactions that generally require a recommendation and referral to the state/RO:

- Addition of outpatient physician therapy/outpatient speech pathology extension site
- Addition of hospice satellite
- Addition of home health agency branch
- Change in type of Prospective Payment System (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 transfer

In these situations, the Provider Enrollment, Chain and Ownership System (PECOS) record should not be switched to "approved" until the contractor receives notice from the RO that the latter has authorized the transaction. However, if the contractor knows that the particular state/RO in question typically does not review, approve, or deny this type of transaction, the contractor need not send the transaction to the state/RO for approval and shall instead follow the instructions in (B)(2) below.

(If the transaction is a stock transfer, the contractor need not send the transaction to the state/RO for approval (and shall instead follow the instructions in (B)(2) below) if the following three conditions are met:

(1) The contractor is confident that the transaction is merely a transfer of stock and not a CHOW,

(2) The RO in question (based on the contractor's past experience with this RO) does not treat stock transfers as potential CHOWs, and

(3) The contractor knows that the particular state/RO in question does not review, approve, or deny this type of transaction.

If any of these 3 conditions are not met, the contractor shall send the transaction to the state/RO for approval.)

RO approval for the transactions listed in (B)(1) may be furnished to the contractor via tie-in notice, letter, e-mail, fax, or even telephone; the contractor may accept any of these formats.

If the RO (after receiving the transaction from the contractor for review) notifies the contractor that it does not normally review/approve/deny such transactions, the contractor may finalize the transaction (e.g., switch the PECOS record to "approved).

2. Post-Approval RO Contact Required

Form CMS-855A 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 hospital subunits

- Legal business name, tax identification number, or "doing business as 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

- The transactions (excluding stock transfers) described in (B)(1) for which the contractor knows that the state/RO does not issue approvals/denials

- Stock transfers for which the 3 conditions mentioned in (B)(1) are met.

For these transactions, the contractor shall: (1) notify the provider via letter, fax, e-mail, or telephone that the change has been made, and (2) 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 shall specify the type of information that is changing.

3. All Other Changes of Information

For all Form CMS-855A change requests not identified in (B)(1) or (B)(2) above, the contractor shall notify the provider via letter, fax, 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.

4. Revalidations, Reactivations and Complete Form CMS-855 Applications

In situations where the provider submits a: (1) Form CMS-855A reactivation, (2) Form CMS-855A revalidation, or (3) full Form CMS-855A as part of a change of information (i.e., the provider has no 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 one of the categories in (B)(1) above. For instance, if a revalidation application reveals a new hospital psychiatric unit that was never reported to CMS via the Form 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 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 one of the categories in (B)(2) 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 or approval letter from the RO for a transaction/change regarding information that is not collected on the Form CMS-855A, the contractor need not ask the provider to submit a Form CMS-855A 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 Medicare participation because the provider no longer meets the conditions of participation, the contractor shall adhere to the instructions in section 15.27.2 of this chapter with respect to revoking the provider's/supplier's enrollment*, as the supplier is no longer in compliance with Medicare enrollment regulations*.

The revocation shall be recorded in PECOS using the status reason of "Non-Compliance: Provider/Supplier Type Requirements Not Met." Contractors shall ***not*** *identify the involuntary termination action in PECOS as a Deactivation with a status reason of "Voluntarily Withdrawal from the Medicare Program."*

In addition, contractors shall enter the appropriate enrollment bar and issue a revocation letter to the certified provider or supplier using 42 CFR §424.535(a)(1), as the legal basis for the revocation. The letter shall also contain the effective date of the revocation, appeal rights and the length of the enrollment bar. If CMS learns that the terminated provider plans to receive further surveys during the reasonable assurance period, then CMS will rescind the enrollment bar. The issuance of the Tie-Out for non-compliance of CMS enrollment requirements, conditions of participation, or conditions of coverage is sufficient to revoke.

E. Other Procedures Related to Tie-In Notices, Tie-Out Notices and Approval Letters

1. Receipt of Tie-In When Form CMS-855A Not Completed - If the contractor receives a tie-in notice or approval letter from the RO but the provider never completed the necessary Form CMS-855A, the contractor shall have the provider complete and submit said form. 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 notices, tie-out notices or approval letters 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 RO has 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 Form CMS-855A. 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 Logging and Tracking (L & T) Record Unnecessary - The contractor is not required to create a new L & T record in PECOS when the tie-in notice arrives, 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.

15.7.8.4 - Ambulatory Surgical Centers (ASCs)/Portable X-ray Suppliers (PXRS) Tie-In/Tie-Out Notices and Referrals to the State/RO

(Rev.711 Issued: 04-25-17, Effective: 05-15-17 Implementation: 05-15-17)

(For purposes of this section 15.7.8.4, 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 ASC's/PXRS's participation in Medicare should be terminated.)

A. Issuance of Tie-In/Tie-Out Notices

A tie-in or tie-out notice is 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 requires a referral and recommendation to the state/RO.

(Depending on the specific RO, certain changes of information may also result in the issuance of a CMS-2007.)

B. Form CMS-855B Changes of Information, Stock Transfers, and Other Transactions

1. 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 transfer

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

In these situations, the Provider Enrollment, Chain and Ownership System (PECOS) record should not be switched to "approved" until the contractor receives notice from the RO that the latter has authorized the transaction. However, if the contractor knows that the particular state/RO in question typically does not review, approve, or deny this type of transaction, the contractor need not send the transaction to the state/RO for approval and shall instead follow the instructions in (B)(2) below.

(If the transaction is a stock transfer, the contractor need not send the transaction to the state/RO for approval (and shall instead follow the instructions in (B)(2) below) if the following three conditions are met:

(1) The contractor is confident that the transaction is merely a transfer of stock and not a CHOW,

(2) The RO in question (based on the contractor's past experience with this RO) does not treat stock transfers as potential CHOWs, and

(3) The contractor knows that the particular state/RO in question does not review, approve, or deny this type of transaction.

If any of these 3 conditions are not met, the contractor shall send the transaction to the state/RO for approval.)

RO approval for the transactions listed in (B)(1) may be furnished to the contractor via tie-in notice, letter, e-mail, fax, or even telephone; the contractor may accept any of these formats.

If the RO (after receiving the transaction from the contractor for review) notifies the contractor that it does not normally review/approve/deny such transactions, the contractor may finalize the transaction (e.g., switch the PECOS record to "approved).

2. 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
- Legal business name, tax identification number or "doing business as" name changes that do not constitute a CHOW
- Address changes that do not require a survey of the new location
- The transactions (excluding stock transfers) described in (B)(1) for which the contractor knows that the state/RO does not issue approvals/denials
- Stock transfers for which the 3 conditions mentioned in (B)(1) are met.

For these transactions, the contractor shall: (1) notify the supplier via letter, fax, e-mail, or telephone that the change has been made, and (2) 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. The notice to the state/RO shall specify the type of information that is changing.

3. All Other Changes of Information

For all Form CMS-855B change requests not identified in (B)(1) or (B)(2) above, the contractor shall notify the supplier via letter, fax, 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.

4. Revalidations, Reactivations and Complete CMS-855 Applications

In situations where the provider submits a: (1) Form CMS-855B reactivation, (2) Form CMS-855B revalidation, or (3) full Form CMS-855B as part of a change of information (i.e., the supplier has no 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 one of the categories in (B)(1) above. For instance, if a revalidation application reveals a new practice location that was never reported to CMS via the Form 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 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 one of the categories in (B)(2) 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 or approval letter for a transaction that concerns information not collected on the Form CMS-855B application, the contractor need not ask the supplier to submit a Form 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 Medicare participation because the supplier no longer meets the conditions of coverage, the contractor shall adhere to the instructions in section 15.27.2 of this chapter with respect to revoking the supplier's enrollment*, as the supplier is no longer in compliance with Medicare enrollment regulations*.

The revocation shall be recorded in PECOS using the status reason of "Non-Compliance: Provider/Supplier Type Requirements Not Met." Contractors shall ***not*** *identify the involuntary termination action in PECOS as a Deactivation with a status reason of "Voluntarily Withdrawal from the Medicare Program."*

In addition, contractors shall enter the appropriate enrollment bar and issue a revocation letter to the certified provider or supplier using 42 CFR §424.535(a)(1), as the legal basis for the revocation. The letter shall also contain the effective date of the revocation, appeal rights and the length of the enrollment bar. If CMS learns that the terminated provider plans to receive further surveys during the reasonable assurance period, then CMS will rescind the enrollment bar. The issuance of the Tie-Out for non-compliance of CMS enrollment requirements, conditions of participation, or conditions of coverage is sufficient to revoke.

E. Other Procedures Related to Tie-In/Tie-Out Notices and Approval Letters

1. Receipt of Tie-In When Form CMS-855B Not Completed

If the contractor receives a tie-in notice or approval letter from the RO but the supplier never completed the necessary Form CMS-855B, the contractor shall have the supplier complete and submit said form. 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 notices, tie-out notices or approval letters 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 RO has 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 Form 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 Logging and Tracking (L & T) Record Unnecessary

The contractor is not required to create a new L & T record in PECOS when the tie-in notice or approval letter arrives, 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. Supplier Inquiries

Once the contractor makes its recommendation for approval to the state/RO, any inquiry the contractor receives from the supplier 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.

15.23.2 – Release of Information

(Rev.711 Issued: 04-25-17, Effective: 05-15-17 Implementation: 05-15-17)

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 outside person or entity, unless specified otherwise in this chapter. (Provider-specific data includes, but are not limited to, owners/managers, adverse legal history, practice locations, group affiliations, effective dates, etc.) Examples of outside persons or entities include, but are not restricted 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(s) (section 15 of the CMS-855), delegated official(s) (section 16), contact persons (section 13), or authorized surrogate users. 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, and (2) the contractor has no reason to question the authenticity of the person’s signature. The letter can be mailed, faxed, or emailed to the contractor.
- 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 Form 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 emails, the contractor shall not transmit sensitive data, such as social security numbers or employer identification numbers.
- The contractor may not send PECOS screen printouts to the provider.
- With the exception of CMS-855S applications, if any contact person listed on a provider or supplier’s enrollment record, requests a copy of a provider or supplier’s Medicare approval letter or revalidation notice, the contractor shall send to the contact person via email, fax or mail. This excludes Certification Letters (Tie In notices), as the contractor is not responsible for generating these approvals.

15.23.3 – File Maintenance

(Rev.711 Issued: 04-25-17, Effective: 05-15-17 Implementation: 05-15-17)

The contractor shall maintain and store all documents relating to the enrollment of a provider into the Medicare program. These documents include, but are not limited to, Medicare enrollment applications and all supporting documents, attachments, correspondence, and appeals submitted in conjunction with an initial enrollment, reassignment, change of enrollment, revalidation, etc.

Supporting documentation includes, but is not limited to:

- Copies of Federal, State and/or local (city/county) professional licenses, certifications and/or registrations;

- Copies of Federal, State, and/or local (city/county) business licenses, certifications and/or registrations;

- Copies of professional school degrees or certificates or evidence of qualifying course work;

- Copies of CLIA certificates and FDA mammography certificates, *and;*

- *Copies of any entry found on the Medicare Exclusion Database (MED) report that leads to a provider or supplier's revocation.*

The contractor shall dispose of the aforementioned records as described below:

1) Provider/Supplier and Durable Medical Equipment Supplier Application

a. Rejected applications as a result of provider failing to provide additional information

Disposition: Destroy when 7 years old.

b. Approved applications of provider/supplier

Disposition: Destroy 15 years after the provider/supplier's enrollment has ended.

c. Denied applications of provider/supplier.

Disposition: Destroy 15 years after the date of denial.

d. Approved application of provider/supplier, but the billing number was subsequently revoked.

Disposition: Destroy 15 years after the billing number is revoked.

e. Voluntary deactivation of billing number

Disposition: Destroy 15 years after deactivation.

f. Provider/Supplier dies

Disposition: Destroy 7 years after date of death.

2) Electronic Mail and Word Processing System Copies

a. Copies that have no further administrative value after the recordkeeping copy is made. These include copies maintained by individuals in personal files, personal electronic mail directories, or other personal directories on hard disk or network drives, and copies on shared network drives that are used only to produce the recordkeeping copy.

Disposition: Delete within 180 days after the recordkeeping copy has been produced.

b. Copies used for dissemination, revision or updating that are maintained in addition to the recordkeeping copy.

Disposition: Delete when dissemination, revision, or updating is complete.

15.24.7 – Approval Letter Guidance

(Rev.711 Issued: 04-25-17, Effective: 05-15-17 Implementation: 05-15-17)

(The contractor may mail, e-mail, or fax the approval letter to the provider or supplier. If the fax or e-mail is not received by the provider or supplier, a letter shall be mailed.)

- Depending on the type of approval, one of the following shall be selected for insertion in the first sentence:

  [Initial Medicare enrollment application]
  [Revalidated Medicare enrollment application]
  [Change of information request]
  [Add/Terminate a Reassignment of Benefits request]

- If provider/supplier is NOT exclusively ordering or certifying, REMOVE the following sentence:

  This application is for the sole purpose of ordering or certifying items or services for Medicare beneficiaries to other providers and suppliers.

- *If the provider/supplier is NOT included in the list found in Section 15.17 of this chapter, REMOVE the following field:*

  Retrospective Billing Date: [Retrospective Billing Date]

- Ordering or Certifying Providers

  The last sentence of the 1st paragraph shall be the following:

  Listed below is your National Provider Identifier (NPI).

  REMOVE paragraph 2 and paragraph 3, which refer to PTAN usage.

  If provider/supplier IS exclusively ordering or certifying, REMOVE the following three fields:

  Practice location: [Address]
  Provider Transaction Access Number (PTAN): [PTAN]
  You are a: [participating]/[non-participating]

  The effective date field shall remain in the letter and reflect the date on which the contractor received the signed paper CMS-855O form or the Web-based certification statement/e-signature.

  Effective date: [Effective date or Termination date of Ordering or Certifying Status]

- Change of Ownership (CHOW) Approvals

  For Change of Ownership (CHOW) approvals, paragraphs #2 and #3 of the letter are optional.

- If letter is NOT approving a Change of Ownership (CHOW), REMOVE the following field:

  Medicare Year End Cost Report Date: [Date]

- On the effective date field, if voluntarily terminating Medicare participation, insert “of termination” after “Effective date”

- Physicians, certain non-physician practitioners, and physician and non-physician practitioner organizations may appeal their effective date made by the contractor (JSM/TDL 11023)

- Supply additional “Medicare Enrollment Information” for each additional location and NPI/PTAN combination) only when approving an Initial or Revalidation application. If multiple locations and NPI/PTAN combinations exist, a separate document identifying this information shall be attached to the approval letter.

- Changes of information submitted to report a change to a data element other than those listed as one of the predefined elements, shall be added to the predefined list under the Medicare Enrollment Information section to acknowledge the change has been incorporated*, along with the effective date of the changed information. The effective date of the changed information shall be either the date of addition, change, or deletion specified on the associated application or the date of receipt of the associated application.*

- The 2nd,3rd and 4th paragraphs may be edited or deleted in appropriate circumstances:

  To start billing, you must use your NPI on all Medicare claim submissions. Because the PTAN is not considered a Medicare legacy identifier, do not report it as an “other” provider identification number to the National Plan and Provider Enumeration System (NPPES).

  Your PTAN has been activated and will be the required authentication element for all inquiries to customer service representatives (CSRs), written inquiry units, and the interactive voice response (IVR) system. The IVR allows you to inquire about claims status, beneficiary eligibility and transaction information.

  If you plan to file claims electronically, please contact our EDI department at [phone number].

- Under “Medicare Enrollment Information, for group member enrollment, the following fields may be added:

  Group National Provider Identifier (NPI): [NPI]
  Group Provider Transaction Access Number (PTAN): [PTAN]

15.24.7.1 – Model Approval Letter

(Rev.711 Issued: 04-25-17, Effective: 05-15-17 Implementation: 05-15-17)

[month] [day], [year]

[Provider/Supplier Name]
[Address]
[City] ST [Zip]

Reference # (Contractor Control Number or NPI)

Dear [Provider/Supplier Name]:

We are pleased to inform you that your [initial Medicare enrollment application]/[revalidated Medicare enrollment application]/[change of information request] is approved. This application is for the sole purpose

of ordering and referring items or services for Medicare beneficiaries to other providers and suppliers. Listed below are your National Provider Identifier (NPI) and Provider Transaction Access Number (PTAN).

To start billing, you must use your NPI on all Medicare claim submissions. Because the PTAN is not considered a Medicare legacy identifier, do not report it as an "other" provider identification number to the National Plan and Provider Enumeration System (NPPES).

Your PTAN has been activated and will be the required authentication element for all inquiries to customer service representatives (CSRs), written inquiry units, and the interactive voice response (IVR) system. The IVR allows you to inquire about claims status, beneficiary eligibility and transaction information.

If you plan to file claims electronically, please contact our EDI department at [phone number].

Medicare Enrollment Information

Provider \ Supplier name:	[Name]
Practice location:	[Address]
National Provider Identifier (NPI):	[NPI]
Provider Transaction Access Number (PTAN):	[PTAN]
Specialty:	[Provider specialty]
You are a:	[participating]/[non-participating]
Effective date:	[Effective date, Effective date of termination *or Change of Information Effective Date*]
Retrospective billing date	*[Retrospective billing date if different than effective date]*
Medicare Year-End Cost Report date:	[Date]
Changed Information:	*[List all updates/changes]*

Please verify the accuracy of your enrollment information.

You are required to submit updates and changes to your enrollment information in accordance with specified timeframes pursuant to 42 CFR §424.516. Reportable changes include, but are not limited to, changes in: (1) legal business name (LBN)/tax identification number (TIN), (2) practice location, (3) ownership, (4) authorized/delegated officials, (5) changes in payment information such as electronic funds transfer information and (6) final adverse legal actions, including felony convictions, license suspensions or revocations, an exclusion or debarment from participation in Federal or State health care program, or a Medicare revocation by a different Medicare contractor.

Providers and suppliers may enroll or make changes to their existing enrollment in the Medicare program using the Internet-based Provider Enrollment, Chain and Organization System (PECOS). Go to: www.cms.hhs.gov/MedicareProviderSupEnroll.

Providers and suppliers enrolled in Medicare are required to ensure strict compliance with Medicare regulations, including payment policy and coverage guidelines. CMS conducts numerous types of compliance reviews to ensure providers and suppliers are meeting this obligation. Please visit the Medicare Learning Network at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/index.html for further information about regulations and compliance reviews, as well as Continuing Medical Education (CME) courses for qualified providers.

Additional information about the Medicare program, including billing, fee schedules, and Medicare policies and regulations can be found at our Web site at [insert contractor's web address] or the Centers for Medicare & Medicaid Services (CMS) Web site at http://www.cms.hhs.gov/home/medicare.asp.

If you disagree with the effective date determination in this letter, you may request a reconsideration before a contractor hearing officer. The reconsideration is an independent review and will be conducted by a person who was not involved in the initial determination. You must request the reconsideration in writing to

this office within 60 calendar days of the postmark date of this letter. The reconsideration must state the issues or findings of fact with which you disagree and the reasons for disagreement. You may submit the additional information with the reconsideration request that you believe may have a bearing on the decision. However, if you have additional information that you would like a hearing officer to consider during the reconsideration or, if necessary, an administrative law judge to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process; you will not have another opportunity to do so unless an administrative law judge specifically allows you to do so under 42 CFR §498.56(e).

The reconsideration request must be signed and dated by the physician, non-physician practitioner or any responsible authorized or delegated official within the entity. Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review.

The reconsideration request should be sent to:

[Name of MAC]
[Address]
[City], ST [Zip]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name]
[Title]
[Company]

15.24.8.6 – Denial Example #5 – Existing or Delinquent Overpayments

(Rev.711 Issued: 04-25-17, Effective: 05-15-17 Implementation: 05-15-17)

[Date]

[Provider/Supplier Name]
[Address]
[City] ST [Zip]

Reference # (Contractor Control Number or NPI)

Dear [Provider/Supplier Name]:

Your application to enroll in Medicare is denied for the following reason(s):
Denial Reason 6: (42 CFR §424.530(a)(6))

The current owner (as defined in § 424.502), physician or non-physician practitioner has an existing overpayment at the time of filing an enrollment application.

Dates: (enter date of existing or delinquent overpayment period)

Pertinent details of action(s) (Whether the person or entity is on a Medicare-approved plan of repayment of payments are currently being offset: Whether the overpayment is currently being appealed; the reason for the overpayment)

If you believe that you are able to correct the deficiencies and establish your eligibility in the Medicare program, you may submit a corrective action plan (CAP) within 30 calendar days after the postmark date of this letter. The CAP should provide evidence that you are in compliance with Medicare requirements. The CAP request must be signed by the authorized of delegated official within the entity. CAP requests should be sent to:

Centers for Medicare & Medicaid Services
Center for Program Integrity
Provider Enrollment & Oversight Group
7500 Security Boulevard
Mailstop Code (AR-18-50)
Baltimore, MD 21244

If you believe that this determination is not correct, you may request a reconsideration before a hearing officer. The reconsideration is an independent review and will be conducted by a person not involved in the initial determination. You must request the reconsideration in writing to this office within 60 calendar days of the postmark date of this letter. The reconsideration must state the issues or findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the reconsideration that you believe may have a bearing on the decision. However, if you have additional information that you would like a hearing officer to consider during the reconsideration or, if necessary, an administrative law judge to consider during a hearing, you must submit that information with you request for reconsideration. This is your only opportunity to submit information during the administrative appeals process; you will not have another opportunity to do so unless an administrative law judge specifically allows you to do so under 42 CFR §489.56(e).

The reconsideration must be signed and dated by the authorized or delegated official within the entity. Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review.

The reconsideration request should be sent to:

Centers for Medicare & Medicaid Services
Center for Program Integrity
Provider Enrollment & Oversight Group
7500 Security Boulevard
Mailstop Code (AR-18-50)
Baltimore, MD 21244

If you have any questions, please contact our office at (phone number) between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name]
[Title]
[Company]