CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 324	Date: February 5, 2010
	Change Request 6780

SUBJECT: Revisions to Model Approval Letters

I. SUMMARY OF CHANGES: Updating the appeal information for the effective date of billing on the model approval letters.

NEW/REVISED MATERIAL
EFFECTIVE DATE: March 8, 2010
IMPLEMENTATION DATE: March 8, 2010

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	10/14.7/Model Approval Letter for Initial Enrollment
R	10/14.8/Model Approval Letter for Change of Information
R	10/14.9/Model Revalidation Approval Letter

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: 324	Date: February 5, 2010	Change Request: 6780

SUBJECT: Revisions to Model Approval Letters

EFFECTIVE DATE: March 8, 2010

IMPLEMENTATION DATE: March 8, 2010

I. GENERAL INFORMATION

A. Background: This change request revises existing model provider enrollment language for the model approval letters.

B. Policy: Contractors shall establish and use model provider enrollment correspondence that clearly informs an applicant about the status or disposition of an enrollment action. Per regulations 42 CFR 405.874, a provider or supplier may only appeal a denial or revocation decision. Accordingly, a physician, non-physician practitioner and a physician or non-physician practitioner group may not formally appeal the established effective date of billing. Of course, if a physician or non-physician practitioner and a physician or non-physician practitioner group notify a Medicare contractor that an error may have occurred, the contractor should review this matter.

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6780.1	Contractors shall establish and use model Provider Enrollment correspondence that clearly informs an applicant about the status or disposition of an enrollment action. As necessary, contractors may revise the model language contained in section 14 for grammatical changes.	X		X	X	X					

III. PROVIDER EDUCATION TABLE

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

IV. SUPPORTING INFORMATION

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

X-Ref Requirement Number	Recommendations or other supporting information:
	None

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

V. CONTACTS

Pre-Implementation Contact(s): Ann Marie Reimer (Vale) Annmarie.reimer@cms.hhs.gov (410) 786-4898
Post-Implementation Contact(s): Ann Marie Reimer (Vale) Annmarie.reimer@cms.hhs.gov (410) 786-4898

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Carriers and Regional Home Health Intermediaries (RHHIs),* use the following statement:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

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

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

14.7 – Model Approval Letter for Initial Enrollment

(Rev.324, Issued: 02-05-10, Effective: 03-08-10, Implementation: 03-08-10)

NOTE: *Per regulations 42 CFR 405.874, a provider or supplier may only appeal a denial or revocation decision. Accordingly, a physician, non-physician practitioner and a physician or non-physician practitioner group may not formally appeal the established effective date of billing. Of course, if a physician or non-physician practitioner and a physician or non-physician practitioner group notify a Medicare contractor that an error may have occurred, the contractor should review this matter.*

CMS alpha representation
Contractor

[Month Day & Year]

[Provider/Supplier Name]
[Address]
[City, State & Zip Code]

Dear [Insert Provider/Suppler name]:

We are pleased to inform you that your Medicare enrollment application is approved. Listed below is the information reflected in your Medicare enrollment record, including your National Provider Identifier (NPI) and Provider Transaction Access Number (PTAN).

If you are an existing Medicare provider and currently do not submit claims electronically, or are new to the Medicare program and plan on filing claims electronically, please contact our EDI department at [insert phone number]. To start billing the Medicare program, you must use your NPI on all Medicare claim submissions. Your PTAN is also activated for use 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 for inquiries concerning claims status, beneficiary eligibility and to check status or other supplier related transactions, therefore keep your PTAN secure. Because the PTAN is not considered a Medicare legacy identifier, do <u>not</u> report this identifier to the National Plan and Provider Enumeration System (NPPES) as an “other” provider identification number.

<u>Medicare Enrollment Information</u>

Provider \ Supplier name:	[Insert name]
Practice location:	[Insert address]
National Provider Identifier (NPI):	[Insert NPI]
Provider Transaction Access Number (PTAN):	[Insert PTAN]
Specialty:	[Insert provider/supplier specialty]

You are a:	[Insert participating or non-participating]
Effective date [Insert "of termination" if the applicant is voluntarily terminating Medicare participation]	[Insert effective date or effective date of termination]

(Repeat for multiple, if necessary, for each additional location and NPI/PTAN combination)

Please verify the accuracy of your enrollment information. *If you disagree with this initial determination or have any questions regarding the information above, call [insert applicable Medicare contractor name] at [insert Medicare contractor phone number] between the hours of [insert hours of operation]. Per regulations 42 CFR 405.874, a provider or supplier may only appeal a denial or revocation decision.*

You are required by regulations found at 42 CFR 424.516 to submit updates and changes to your enrollment information in accordance with specified timeframes. 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 changes in electronic funds transfer information and (6) final adverse legal actions, including felony convictions, license suspensions or revocations of a health care license, 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). To apply via the Internet-based PECOS or to download the CMS-855 enrollment applications, go to http://www.cms.hhs.gov/MedicareProviderSupEnroll.

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

Sincerely,

[Your Name]
[Title]

14.8 – Model Approval Letter for Change of Information

(Rev.324, Issued: 02-05-10, Effective: 03-08-10, Implementation: 03-08-10)

NOTE: *Per regulations 42 CFR 405.874, a provider or supplier may only appeal a denial or revocation decision. Accordingly, a physician, non-physician practitioner and a physician or non-physician practitioner group may not formally appeal the established effective date of*

billing. Of course, if a physician or non-physician practitioner and a physician or non-physician practitioner group notify a Medicare contractor that an error may have occurred, the contractor should review this matter.

CMS alpha representation
Contractor

[Month Day & Year]

[Provider/Supplier Name]
[Address]
[City, State & Zip Code]

Dear [Insert Provider/Suppler name]:

We have approved your information change request. Listed below is the [insert "new" or "updated"] information reflected in your Medicare enrollment record.

Medicare Enrollment Information

Provider \ Supplier name:	[Insert name]
[Insert revised item on the application]:	[Insert updated or changed item on the application]
National Provider Identifier (NPI):	[Insert NPI]
Provider Transaction Access Number (PTAN):	[Insert active or inactive PTAN]
Specialty:	[Insert provider/supplier specialty]
You are a:	[Insert participating or non-participating]
Effective date [Insert "of termination" if the applicant is voluntarily terminating Medicare participation]	[Insert effective date or effective date of termination]
If a Change of Ownership (CHOW, insert Medicare Year-End Cost Report date:	[Insert Month and Day]

(Repeat for multiple, if necessary, for each additional location and NPI/PTAN combination)

Please verify the accuracy of your enrollment information. *If you disagree with the information above, call [insert applicable Medicare contractor name] at [insert Medicare contractor phone number] between the hours of [insert hours of operation]. Per regulations 42 CFR 405.874, a provider or supplier may only appeal a denial or revocation decision.*

ADDITIONAL INFORMATION

If you are an existing Medicare provider and currently do not submit claims electronically, or are new to the Medicare program and plan on filing claims electronically, contact our EDI department at [insert phone number]. To start billing the Medicare program, you must use your NPI on all Medicare claims submissions. Your PTAN will be the required authentication element for all inquiries to customer service representatives (CSRs), written inquiry units and the Interactive Voice Response (IVR) system for inquiries concerning claims status, beneficiary eligibility and to check status or other supplier related transactions, therefore keep your PTAN secure.

To maintain an active enrollment status in the Medicare program, regulations found at 42 CFR 424.516 require that you submit updates and changes to your enrollment information in accordance with specified timeframes. 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 changes in electronic funds transfer information and (6) final adverse legal actions, including felony convictions, license suspensions or revocations of a health care license, 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). To apply via the Internet-based PECOS or to download the CMS-855 enrollment applications, go to http://www.cms.hhs.gov/MedicareProviderSupEnroll.

Sincerely,

[Your Name]
[Title]

14.9 – Model Revalidation Approval Letter

(Rev.324, Issued: 02-05-10, Effective: 03-08-10, Implementation: 03-08-10)

NOTE: *Per regulations 42 CFR 405.874, a provider or supplier may only appeal a denial or revocation decision. Accordingly, a physician, non-physician practitioner and a physician or non-physician practitioner group may not formally appeal the established effective date of billing. Of course, if a physician or non-physician practitioner and a physician or non-physician practitioner group notify a Medicare contractor that an error may have occurred, the contractor should review this matter.*

CMS alpha representation
Contractor

[Month Day & Year]
[Provider/Supplier Name]
[Address]

[City, State & Zip Code]

Dear [Insert Provider/Suppler name]:

We have processed your Medicare enrollment application(s) to revalidate your Medicare enrollment information.

Listed below is the information reflected in your Medicare enrollment record.

Medicare Enrollment Information:

Provider Name:	[Insert name]
Practice Location:	[Insert address]
National Provider Identifier (NPI):	[Insert NPI]
Provider Transaction Access Number (PTAN):	[Insert PTAN]
You are a:	[Insert participating or non-participating]
Effective Date:	[Insert month day, year]

(Repeat for multiple, if necessary, for each additional location and NPI/PTAN combination)

Please verify the accuracy of your enrollment information. *If you disagree with the information above, call [insert applicable Medicare contractor name] at [insert Medicare contractor phone number] between the hours of [insert hours of operation]. Per regulations 42 CFR 405.874, a provider or supplier may only appeal a denial or revocation decision.*

To maintain an active enrollment status in the Medicare program, regulations found at 42 CFR 424.516 require that you submit updates and changes to your enrollment information in accordance with specified timeframes. 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 changes in electronic funds transfer information and (6) final adverse legal actions, including felony convictions, license suspensions or revocations of a health care license, 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). To apply via the Internet-based PECOS or to download the CMS-855 enrollment applications, go to http://www.cms.hhs.gov/MedicareProviderSupEnroll.

Sincerely,

[Your Name]
[Title]