CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-08 Medicare Program Integrity	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 356	**Date: September 24, 2010**
	Change Request 7083

SUBJECT: Manual Redesign

I. SUMMARY OF CHANGES: CMS will reorganize and move information contained in chapter 10 to chapter 15. In addition, CMS will incorporate a limited number of changes to these sections. This change request will organize the sections into more manageable content units that will be easily understood by the providers and suppliers.

EFFECTIVE DATE: October 26, 2010
IMPLEMENTATION DATE: October 26, 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
D	10/3.1.1/Application Rejections
D	10/3.1.2/Denials for Incomplete Applications
D	10/3.2/Returning the Application
D	10/4.3/Adverse Legal Actions/Convictions
D	10/5.1/General Verification Principles
D	10/5.2/Verification of Data
D	10/6.2/Denials
D	10/10/Documentation
D	10/20/Provider Enrollment Fraud Detection Program for High Risk Areas
D	10/20.1/Submission of Proposed Implementation Plan for High Risk Areas
R	15/15.1.1/Definitions
R	15/15.1.2/Medicare Enrollment Application (CMS-855)
R	15/15.1.3/Medicare Contractor Duties
R	15/15.4.2.5/Portable X-Ray Suppliers (PXRS)
R	15/15.4.8/Suppliers Not Eligible to Participate

N	15/15.7/Application Review and Verification Activities
N	15/15.7.2/Verification of Data
N	15/15.7.3/Documentation
N	15/15.8/Initial Determination and Other Administrative Actions
N	15/15.8.1/Returning the Application
N	15/15.8.2/Application Rejections
N	15/15.8.3/Reserved For Future Use
N	15/15.8.4/Denials
N	15/15.8.4.1/Denials for Incomplete Applications
N	15/15.8.4.2/Adverse Legal Actions/Convictions
N	15/15.31/Provider Enrollment Fraud Detection Program for High Risk Areas
N	15/15.31.1/Submission of Proposed Implementation Plan for High Risk Areas

III. FUNDING:

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

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not 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: 356	Date: September 24, 2010	Change Request: 7083

SUBJECT: Manual Redesign

EFFECTIVE DATE: October 26, 2010
IMPLEMENTATION DATE: October 26, 2010

I. GENERAL INFORMATION

A. Background: The Centers for Medicare & Medicaid Services (CMS) will reorganize and move the information contained in chapter 10 to chapter 15. In addition, CMS will incorporate a limited number of changes to these sections (see business requirements below). This change request will organize the sections into more manageable content units that will be easily understood by the providers and suppliers.

B. Policy: There are no changes in CMS policy other than those contained in the business requirements and corresponding manual change.

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	
7083.1	Medicare contractors shall use contents of chapter 15 in lieu of chapter. 10.	X	X	X	X	X					NSC

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: N/A
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

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Post-Implementation Contact(s) for Ch. 15 Manual Redesign: Ann Marie Reimer (Vale) (410) 786-4898

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers,* use only one of the following statements:

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),* include 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.

Medicare Program Integrity Manual
Chapter 15 - Medicare Enrollment

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(Rev.356, 09-24-10)

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15.1.1 – Definitions

(Rev.356, Issued: 09-24-10, Effective: 10-26-10, Implementation: 10-26-10)

Below is a list of terms commonly used in the Medicare enrollment process:

Accredited provider/supplier means a supplier that has been accredited by a CMS-designated accreditation organization.

Advanced diagnostic imaging service means any of the following diagnostic services:

(i) Magnetic *R*esonance *I*maging *(MRI)*.
(ii) Computed *T*omography *(CT).*
(iii) Nuclear *M*edicine.
(iv) Positron *E*mission *T*omography (*PET)*.

Applicant means the individual (practitioner/supplier) or organization who is seeking enrollment into the Medicare program.

Approve/Approval means the enrolling provider or supplier has been determined to be eligible under Medicare rules and regulations to receive a Medicare billing number and be granted Medicare billing privileges.

Authorized Official means an appointed official (e.g., chief executive officer, chief financial officer, general partner, chairman of the board, or direct owner) to whom the organization has granted the legal authority to enroll it in the Medicare program, to make changes or updates to the organization's status in the Medicare program, and to commit the organization to fully abide by the statutes, regulations, and program instructions of the Medicare program.

Billing Agency means a company that the applicant contracts with to prepare, edit and/or submit claims on its behalf.

Change of Ownership (CHOW) is defined in 42 CFR §489.18 (a) and generally means, in the case of a partnership, the removal, addition, or substitution of a partner, unless the partners expressly agree otherwise, as permitted by applicable State law. In the case of a corporation, the term generally means the merger of the provider corporation into another corporation, or the consolidation of two or more corporations, resulting in the creation of a new corporation. The transfer of corporate stock or the merger of another corporation into the provider corporation does not constitute a change of ownership.

CMS-approved accreditation organization means an accreditation organization designated by CMS to perform the accreditation functions specified.

Deactivate means that the provider or supplier's billing privileges were stopped, but can be restored upon the submission of updated information.

Delegated Official means an individual who is delegated by the "Authorized Official," the authority to report changes and updates to the enrollment record. The delegated official must be an individual with an ownership or control interest in (as that term is defined in section 1124(a)(3) of the Social Security Act), or be a W-2 managing employee of, the provider or supplier.

Deny/Denial means the enrolling provider or supplier has been determined to be ineligible to receive Medicare billing privileges.

Enroll/Enrollment means the process that Medicare uses to grant Medicare billing privileges.

Enrollment Application means a paper CMS-855 enrollment application or *the equivalent* electronic enrollment process approved by the Office of Management and Budget (OMB).

Final adverse action means one or more of the following actions:

(i) A Medicare-imposed revocation of any Medicare billing privileges;
(ii) Suspension or revocation of a license to provide health care by any State licensing authority;
(iii) Revocation or suspension by an accreditation organization;
(iv) A conviction of a Federal or State felony offense (as defined in §424.535(a)(3)(i)) within the last 10 years preceding enrollment, revalidation, or re-enrollment; or
(v) An exclusion or debarment from participation in a Federal or State health care program.

Legal Business Name is the name that is reported to the Internal Revenue Service (IRS).

Managing Employee means a general manager, business manager, administrator, director, or other individual that exercises operational or managerial control over, or who directly or indirectly conducts, the day-to-day operation of the provider or supplier, either under contract or through some other arrangement, whether or not the individual is a W-2 employee of the provider or supplier.

(For Part A providers, the Medicare Identification Number (MIN) is the CMS Certification Number (CCN). For Part B suppliers other than suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS), the MIN is the Provider Identification Number (PIN). For DMEPOS suppliers, the MIN is the number issued to the supplier by the NSC).

National Provider Identifier is the standard unique health identifier for health care providers (including Medicare suppliers) and is assigned by the National Plan and Provider Enumeration System (NPPES).

Operational means the provider or supplier has a qualified physical practice location, is open to the public for the purpose of providing health care related services, is prepared to submit valid Medicare claims; and is properly staffed, equipped, and stocked (as applicable, based on the type

of facility or organization, provider or supplier specialty, or the services or items being rendered) to furnish these items or services.

Owner means any individual or entity that has any partnership interest in, or that has 5 percent or more direct or indirect ownership of, the provider or supplier as defined in sections 1124 and 1124(A) of the Social Security Act.

Physician or non-physician practitioner organization means any physician or non-physician practitioner entity that enrolls in the Medicare program as a sole proprietorship or organizational entity.

Prospective Provider means any entity specified in the definition of "provider" in 42 CFR §498.2 that seeks to be approved for coverage of its services by Medicare.

Prospective Supplier means any entity specified in the definition of "supplier" in 42 CFR §405.802 that seeks to be approved for coverage of its services under Medicare.

Provider is defined at 42 CFR §400.202 and generally means a hospital, critical access hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency or hospice, that has in effect an agreement to participate in Medicare; or a clinic, rehabilitation agency, or public health agency that has in effect a similar agreement but only to furnish outpatient physical therapy or speech pathology services; or a community mental health center that has in effect a similar agreement but only to furnish partial hospitalization services.

Reassignment means that an individual physician or non-physician practitioner, except physician assistants, has granted a clinic or group practice the right to receive payment for the practitioner's services.
Reject/Rejected means that the provider or supplier's enrollment application was not processed due to incomplete information or that additional information or corrected information was not received from the provider or supplier in a timely manner.

Revoke/Revocation means that the provider or supplier's billing privileges are terminated.

Supplier is defined in 42 CFR §400.202 and means a physician or other practitioner, or an entity other than a provider that furnishes health care services under Medicare.

Tax Identification Number means the number (either the Social Security Number (SSN) or Employer Identification Number (EIN)) the individual or organization uses to report tax information to the IRS.

15.1.2 –Medicare Enrollment Application (CMS-855)

(Rev.356, Issued: 09-24-10, Effective: 10-26-10, Implementation: 10-26-10)

Providers and suppliers*, including physicians may* enroll or update their Medicare enrollment record using *the*:

- *Internet-based Provider Enrollment, Chain and Ownership System (PECOS), or*

- *Paper enrollment application process (e.g., CMS-855I).*

The Medicare enrollment applications *are* issued by CMS and approved by OMB. (When available, the forms can be accessed through the Provider Enrollment, Chain and Ownership System's (PECOS) Web-based enrollment process, which is based off of the information collected on the CMS-855 forms).

The five forms are distinguished as follows:

- CMS-855I - This form should be completed by individual practitioners, including physicians and non-physician practitioners, who render Medicare Part B services to Medicare beneficiaries. (This includes a physician or practitioner who: (1) is the sole owner of a professional corporation, professional association, or limited liability company, and (2) will bill Medicare through this business entity).

- CMS-855R - An individual who renders Medicare Part B services and seeks to reassign his or her benefits to an eligible entity should complete this form for each entity eligible to receive reassigned benefits. The person must be enrolled in the Medicare program as an individual prior to reassigning his or her benefits.

- CMS-855B - This application should be completed by a supplier organization (e.g., ambulance company) that will bill Medicare for Part B services furnished to Medicare beneficiaries. It is not used to enroll individuals.

- CMS-855A - This application should be completed by institutional providers (e.g., hospital) that will furnish Medicare Part A services to Medicare beneficiaries.

- CMS-855S – This application should be completed by DMEPOS suppliers. The NSC is responsible for processing this type of enrollment application.

A separate application must be submitted for each provider/supplier type.
When a prospective provider or supplier contacts the contractor to obtain a *paper enrollment* CMS-855 application, the contractor shall furnish:

- *Encourage a provider or supplier to submit the enrollment application using Internet-based PECOS.*

- The CMS Web site at which the applications can be accessed (www.cms.hhs.gov/MedicareProviderSupEnroll);

- Notification of any supporting documentation required for the applicant's provider/supplier type;

- The Electronic Funds Transfer Authorization Agreement (CMS-588) (Note: The NSC is only required to collect the CMS-588 with initial enrollment applications);

- The Electronic Data Interchange (EDI) agreement (Note: This does not apply to the NSC);

- The Medicare Participating Physician or Supplier Agreement (CMS-460), with an explanation of the purpose of the agreement and how it differs from the actual enrollment process. (This only applies to carriers.)

- The contractor's address, so that the applicant knows where to return the completed application;

- If the applicant is a certified supplier or provider, notification that the applicant should contact the State agency for any state-specific forms and to begin preparations for a State survey. (This does not apply for those certified entities, such as FQHCs, that do not receive a State survey.) The notification can be given in any manner the contractor chooses.

15.1.3 – Medicare Contractor Duties

(Rev.356, Issued: 09-24-10, Effective: 10-26-10, Implementation: 10-26-10)

The contractor must adhere to the processing guidelines established in this chapter 1***5*** (hereinafter generally referred to as "this manual"). In addition, the contractor shall assign the appropriate number of staff to the Medicare enrollment function to meet established processing timeframes.

The contractor shall provide training to new employees and provide refresher training, as necessary, to existing employees to ensure that each employee processes enrollment applications in a timely, consistent, and accurate manner. Training shall include, at a minimum:

- An overview of the Medicare program;

- A review of applicable regulations, manual instructions and other guidance issued by CMS;

- A review of the contractor's enrollment processes and procedures; and

- Training regarding the Provider Enrollment, Chain and Ownership System (PECOS).

- For new employees, the contractor shall also:

- Provide side-by-side training with an experienced provider enrollment analyst;

- Test the new employee to ensure that the analyst understands Medicare enrollment policy and contractor processing procedures, including the use of PECOS; and

- Conduct end-of-line quality reviews for 6 months after training or until the analyst demonstrates a clear understanding of Medicare enrollment policy and contractor procedures.

- Contractors shall process all enrollment actions (i.e., initials, changes, revalidations and reactivations) through PECOS.

- Contractors shall deactivate or revoke in MCS and FISS only if the provider or supplier is not in PECOS.

- Contractors shall close or delete any aged logging and trackings (L&Ts) that exceed 120 days for which there is not an associated enrollment application.

- Contractors shall participate in UAT testing for each PECOS release.

- When requested, contractors shall attend scheduled PECOS training.
- Contractors shall report PECOS validation and production processing problems through the designated tracking system for each system release.

Moreover, each contractor shall develop (and update as needed) a written training guide for new and current employees on the proper processing of CMS-855 applications as well as the appropriate entrance of data into PECOS.

Conduct Prescreening

- Review the application to determine that it is complete and that all information and supporting documentation required for the applicant's provider/supplier type has been submitted on and with the appropriate enrollment application.

Conduct Verification, Validation, and Final Processing

- Verify and validate the information collected on the enrollment application *(see section 7, of chapter 15 for additional information).*

- Coordinate with State survey/certification agencies and regional offices (ROs), as needed

- Collect and maintain the application's certification statement (in house) to verify and validate Electronic Funds Transfer (EFT) changes. The change request signature must be checked against the original signature to determine the validity of any change to EFT information. This check can be made against a digital/photo image kept in-house.

- Confirm that the applicant, all individuals and entities listed on the application, and any names or entities ascertained through the use of an independent verification source, are not presently excluded from the Medicare program by the HHS Office of the Inspector General (OIG). Contractors shall *verify eligibility using the* Medicare Exclusion Database (MED), and the General Services *Excluded Parties List System.*

15.4.2.5 - Portable X-Ray Suppliers (PXRSs)

(Rev.356, Issued: 09-24-10, Effective: 10-26-10, Implementation: 10-26-10)

A. General Background Information

A portable x-ray supplier (PXRS) moves its x-ray equipment from place to place, performing x-ray services at various locations. To qualify as a PXRS, an entity must meet the conditions for coverage discussed in 42 CFR §486.100-110. These include, but are not limited to:

- Possess a State license or registration to perform the services (assuming the State licenses/registers PXRSs) (42 CFR §486.100(a));

- All personnel operating the equipment are licensed/registered in accordance with State and local laws (and meet certain other training requirements) (42 CFR §486.100(b));

- All PXRS equipment is licensed/registered in accordance with State and local laws (42 CFR §486.100(c));

- All suppliers of PXRS agree to render such services in conformity with Federal, State and local laws relating to safety standards (42 CFR §486.100(d));

- The PXRS services are provided under the supervision of a qualified physician. (42 CFR §486.102(a)). Additionally, the supervising physician must either:

    - Own the equipment (which must be operated only by his/her employees); or

    - Certify on a yearly basis that he/she periodically checks the procedural manuals and observes the operators' performance, and that the equipment and personnel meet all Federal, State, and local requirements

- The PXRS are provided under the supervision of a licensed doctor of medicine or osteopathy who is qualified in advanced training and experience in the use of x-rays for diagnostic purpose (42 CFR §486.102(b));

- The PXRS has an orientation program for its personnel (42 CFR §486.104(b));

- All equipment is inspected at least every 2 years. (42 CFR §486.110).

A PXRS can be simultaneously enrolled as a mobile IDTF, though they cannot bill for the same service. Note that PXRSs require a State survey, while mobile IDTFs do not (although IDTFs do require a site visit); moreover, PXRSs can bill for transportation and set-up, while mobile IDTFs cannot.

PXRSs do not have *a* supplier agreement.

B. Enrollment of PXRS

In order to enroll as a PXRS, a supplier must complete a Form CMS-855B, undergo a State survey, and secure RO approval. One of the most important parts of any PXRS's enrollment application is Section 4. Here, the PXRS must furnish, among other things, the following information:

- Whether it furnishes services from a "mobile facility" or "portable unit." The former term typically describes a vehicle that travels from place to place to perform services inside the vehicle. Examples of such vehicles include mobile homes or trailers. A "portable unit" exists when a supplier transports medical equipment to a particular location. Unlike with mobile facilities, the equipment on a portable unit is separate from and unattached to the vehicle.

- A PXRS can be either a mobile facility or portable unit, although it usually is the latter. A mobile IDTF, on the other hand, while it too can be either, is typically a mobile facility.

- Its base of operations. This is where personnel are dispatched from and where equipment is stored. It may or may not be the same address as the practice location(s).

- All geographic locations at which services will be rendered.

- Vehicle information IF the services will be performed inside or from the vehicle. Copies of all licenses and registrations must be submitted as well.

As stated in Pub. 100-07, chapter 2, section 2422, the "residence used as the patient's home" can include a SNF or hospital that does not provide x-ray services for its patients and arranges for these services through a PXRS, such as a mobile unit. However, the mobile unit can neither be fixed at any one location nor permanently located in a SNF or a hospital.

C. Additional Information

For more information on PXRSs, refer to:

- Section 1861(s)(3) of the Social Security Act;

- 42 CFR Parts 486.100 – 486.110;

- Pub. 100-07, chapter 2, sections 2420 – 2424B (State Operations Manual);

- Pub. 100-02, chapter 15, sections 80.4 – 80.4.4 (Benefit Policy Manual); and

- Pub. 100-04, chapter 13, sections 90 – 90.5 (Claims Processing Manual).

15.4.8 - Suppliers Not Eligible to Participate

(Rev.356, Issued: 09-24-10, Effective: 10-26-10, Implementation: 10-26-10)

Below is a list of suppliers who frequently attempt to enroll in *the* Medicare *Program* but are not eligible to do so.

If the contractor receives an enrollment application *from any of the following individuals or organizations below*, the contractor shall deny the application without development.

- Acupuncturist
- Assisted Living Facilities
- Birthing Centers
- Certified Alcohol and Drug Counselor
- Certified Social Worker
- Drug and Alcohol Rehabilitation Counselor
- Hearing Aid Center/Dealer
- Licensed Alcoholic and Drug Counselor
- Licensed Massage Therapist (LMT)
- Licensed Practical Nurse (LPN)
- Licensed Professional Counselor
- Marriage Family Therapist (MFT)
- Masters of Social Work
- Mental Health Counselor
- National Certified Counselor
- Occupational Therapist Assistant
- Physical Therapist Assistant
- Registered Nurse
- Speech and Hearing Center
- Substance Abuse Facility

15.7 – Application Review and Verification Activities

(Rev.356, Issued: 09-24-10, Effective: 10-26-10, Implementation: 10-26-10)

Unless stated otherwise in this manual, the instructions in sections 7 through 7.3 apply to the CMS-855A, the CMS-855B and the CMS-855I. These instructions are in addition to, and not in lieu of, all other instructions in this manual.

15.7.1 – General Verification Principles

(Rev.356, Issued: 09-24-10, Effective: 10-26-10, Implementation: 10-26-10)

Unless stated otherwise in this manual, the contractor shall comply with the following principles when processing CMS-855 enrollment applications:

- ***Completeness:*** *The contractor shall ensure that the provider completed all required data elements on the CMS-855 (including all effective dates) and that all supporting documentation has been furnished. The contractor shall also ensure that the provider completed the application in accordance with the instructions on the CMS-855 form. (Note that the instructions on the CMS-855 shall be read and applied in addition to, and not in lieu of, the instructions in this manual.)*

- ***Written Data Elements:*** *Unless stated otherwise in this manual or other CMS directive, the provider shall complete all required data elements on the CMS-855 via the application itself. The contractor shall not accept any required information captured on the CMS-855 via telephone, letterhead, e-mail, etc., regardless of the relative materiality of the data element in question.*

- ***Validation:*** *The contractor shall verify and validate all information furnished by the provider on the CMS-855. (See section 7.2 below for more information.)*

- ***Photocopying Pages*** *- The contractor may accept photocopied pages in any CMS-855 application it receives so long as the application contains an original signature. For example, suppose a corporation wants to enroll five medical clinics it owns. The section 5 data on the CMS-855B is exactly the same for all five clinics. The contractor may accept photocopied section 5 pages for these providers. However, original signatures must be furnished in section 15 of each application.*

- ***White-Out & Highlighting*** *- The contractor shall not write on, or highlight any part of, the original CMS-855 application or any supplementary pages the applicant submits. Provider usage of white-out is acceptable, although the contractor should contact the applicant to resolve any ambiguities. In addition, the contractor must determine whether the amount of white-out used on a particular application is within reason. For instance, if an entire application page is whited-out, the contractor should request that the page be resubmitted.*

15.7.2 – Verification of Data

(Rev.356, Issued: 09-24-10, Effective: 10-26-10, Implementation: 10-26-10)

The general purpose of the verification process is to determine if any of the data furnished on the CMS-855 is incorrect. The contractor may begin the verification process at any time, including during the prescreening phase.

A. Concurrent Reviews

If the contractor receives multiple CMS-855s for related entities, it can perform concurrent reviews of similar data. For instance, suppose a chain home office submits initial CMS-855A applications for four of its chain providers. The ownership information (sections 5 and 6) and chain home office data (section 7) is the same for all four providers. The contractor need only

verify the ownership and home office data once; it need not do it four times – once for each provider. However, the contractor shall document in each provider's file that a single verification check was made for all four applications.

For purposes of this requirement: (1) there must be some sort of organizational, employment, or other business relationship between the entities, and (2) the applications must have been submitted simultaneously – or at least within a few weeks of each other. As an illustration, assume that Group Practice A submits an initial CMS-855B on January 1. Group Practice B submits one on October 1. Section 6 indicates that Joe Smith is a co-owner of both practices, though both entities have many other owners that are not similar. In this case, the contractor must verify Mr. Smith's data in both January and October. It cannot use the January verification and apply it to Group B's application because: (1) the applications were submitted nine months apart, and (2) there is no evidence that the entities are related. (On the other hand, a CMS-855I, CMS-855B, and CMS-855R enrollment package would probably meet the two criteria above.)

B. Mechanisms of Verification

Unless stated otherwise in this manual or in other CMS directives (e.g., JSMs), the contractor shall verify all data furnished on the CMS-855 via the most cost-effective method available. Such data includes, but is not limited to:

- *Adverse legal history of the provider and all entities and persons listed in sections 5 and 6 of the CMS-855.*

- *For non-certified suppliers (e.g., physician clinics), all practice locations and phone numbers listed in section 4 of the CMS-855.*

- *Legal business names and employer identification numbers of all entities listed in sections 5, 7, 8, and 12 of the CMS-855.*

Examples of verification techniques include:

- ***Phone number of provider's practice location or billing agency -** Calling the number listed on the application directly; checking the Yellow Pages.*

- ***Provider's practice location -** Checking the Yellow Pages; conducting a site visit.*

- ***Provider's "doing business as" name –** Searching State Web sites*

If the discrepancy is found between the information of the application and the data found during the verification process, the contractor shall contact the provider for clarification.

In addition:

- *There may be instances where CMS directs contractors to verify certain data via the Medicare Exclusion Database and/or the GSA Excluded Parties List System. If a potential hit is found on the GSA List and the contractor needs to make a positive identity, it shall contact the agency that took the action for further information; based on this data, the contractor shall determine whether it is the same person. If a positive match still cannot be made, the contractor may approve the application.*

- *The contractor is not required to use the Fraud Investigation Database (FID) when processing incoming enrollment applications, including changes of information. If the contractor chooses to use the FID on a particular provider, owner, etc., and the person/entity appears on the FID, the contractor should continue to process the application. However, it should refer the matter to the PSC.*

- *In some instances, a contractor may need to contact another Medicare contractor for information regarding the provider. The latter contractor shall respond to the former contractor's request within three business days absent extenuating circumstances.*

15.7.3 - Documentation

(Rev.356, Issued: 09-24-10, Effective: 10-26-10, Implementation: 10-26-10)

To ensure that proper internal controls are maintained and that important information is recorded in case of potential litigation, the contractor shall maintain documentation as outlined in this section 7.3. CMS cannot stress enough how crucial it is for contractors to document their actions as carefully and thoroughly as possible.

Note that these requirements are in addition to, and not in lieu of, all other documentation or document maintenance requirements that CMS has mandated.

A. Written and Telephonic Communications

*(For purposes of this section **7.3**, "written correspondence" includes faxes and e-mails.)*

The contractor shall:

- *Retain copies of all written correspondence pertaining to the provider, regardless of whether the correspondence was initiated by the contractor, the provider, CMS, State officials, etc.*

- *Document when it sends written letters and faxes to providers. For instance, if the carrier crafts an approval letter to the supplier dated March 1 but sends it out on March 3, the contractor shall note this in the file.*

- *Document all referrals to CMS, the PSC, or the OIG.*

- *Document any and all actual or attempted telephonic or face-to-face contacts with the provider, any representative thereof, or any other person regarding a provider. This includes, but is not limited to, the following situations:*

- *Telephoning a provider about its application. (Even if the provider official was unavailable and a voice mail message was left, this must be documented.)*

- *Requesting information from the State or another contractor concerning the applicant or enrollee;*

- *Contacting the PSC for an update concerning an application sent to them;*

- *Phone calls from the provider;*

- *Conducting a meeting at the contractor's headquarters/offices with officials from a hospital concerning problems with its application;*

- *Contacting CO or the RO's survey and certification staff – and receiving instructions there from - about a problem the contractor is having with an applicant or an existing provider;*

- *Contacting the provider's billing department with a question about the provider.*

When documenting oral communications, the contractor shall indicate: (1) the time and date of the call or contact; (2) who initiated contact; (3) who was spoken with; and (4) what the conversation pertained to. Concerning the last requirement, the contractor need not write down every word that was said during the conversation. Rather, the documentation should merely be adequate to reflect the contents of the conversation. The documentation can be stored electronically, if the contractor can provide access within 24 hours upon request.

Note that the documentation requirements in this subsection (A) only apply to enrolled providers and to providers that have already submitted an enrollment application. In other words, these documentation requirements go into effect only after the provider submits an initial application. To illustrate, if a hospital contacts the contractor requesting information concerning how it should enroll in the Medicare program, this need not be documented because the hospital has not yet submitted an enrollment application.

If an application is returned per section 8.1 of this manual, the contractor shall document this. The manner of documentation lies within the contractor's discretion.

B. Verification of Data Elements

Once the contractor has completed its review of the CMS-855 (e.g., approved/denied application, approved change request), it shall provide a written statement asserting that it has: (1) verified all data elements on the application, and (2) reviewed all applicable names on the CMS-855 against Qualifier.net, the MED, and the GSA debarment list. The statement must be signed and dated. It can be drafted in any manner the contractor chooses so long as it certifies that the above-mentioned activities were completed. The record can be stored electronically.

For each person or entity that appeared on the MED or GSA lists, the contractor shall document the finding via a screen printout. In all other situations, the contractor is not encouraged to

document their reviews via screen printouts. Simply using the verification statement described above is sufficient. Although the contractor has the discretion to use screen prints if it so chooses, the verification statement is still required.

15.8 – Initial Determinations and Other Administrative Actions

(Rev.356, Issued: 09-24-10, Effective: 10-26-10, Implementation: 10-26-10)

15.8.1 – Returning the Application

(Rev.356, Issued: 09-24-10, Effective: 10-26-10, Implementation: 10-26-10)

A. Immediate Returns

The contractor shall immediately return the enrollment application to the provider in the instances described below. This policy applies to all applications identified in sections 4.1 and 4.2 of this manual:

- *There is no signature on the CMS-855 application or Internet-Based PECOS Certification Statement;*
- *The provider submits the outdated paper version of the paper CMS-855 application;*
- *The application contains a copied or stamped signature;*
- *The signature on the application is not dated;*
- *The CMS-855I application was signed by someone other than the individual practitioner applying for enrollment;*
- *The applicant failed to submit all of the forms needed to process a reassignment package within 15 calendar days of receipt (as described in section 5.4 of this manual);*
- *The applicant sent its CMS-855 to the wrong contractor (e.g., the application was sent to Carrier X instead of Carrier Y);*
- *The applicant completed the form in pencil;*
- *The applicant submitted the wrong application (e.g., a CMS-855B was submitted to a fiscal intermediary);*
- *If a Web-generated application is submitted, it does not appear to have been downloaded off of CMS's Web site;*
- *An old owner or new owner in a CHOW submitted its application more than 3 months prior to the anticipated date of the sale. (This only applies to fiscal intermediaries.)*

- *The application was faxed or e-mailed in;*

- *The contractor received the application more than 30 days prior to the effective date listed on the application. (This does not apply to certified providers, ASCs, or portable x-ray suppliers.);*

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

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

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

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

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

The contractor need not request additional information in any of the scenarios described above. Thus, for instance, if the application was not signed, the contractor can return the application immediately.

***NOTE:** The difference between a "rejected" application and a "returned" application; the former is based on the provider's failure to respond to the contractor's request for missing or clarifying information. A "returned" application is considered a non-application.*

For CMS-855A and CMS-855B applications, if the form is signed but it appears the person does not have the authority to do so, the contractor shall process the application normally and follow the instructions in sections 4.15 and 4.16 accordingly. Returning the application on this basis alone is not permitted.

B. Procedures for Returning the Application

If the contractor returns the application:

- *It shall notify the provider via letter or e-mail that the application is being returned, the reason(s) for the return, and how to reapply.*

- *It shall not enter the application into PECOS. No L & T record shall be created.*

- *Any application resubmission must contain a brand new certification statement page containing a signature and date. The provider cannot simply add its signature to the original certification statement it submitted.*

- *Return all other documents submitted with the application (e.g., CMS-588, CMS-460).*

C. EFT Agreements

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

15.8.2 – Application Rejections

(Rev.356, Issued: 09-24-10, Effective: 10-26-10, Implementation: 10-26-10)

(This section 8.2 does not apply to the following individuals and organizations that are submitting an initial application, a change request, or a reassignment:

1. *Physicians*
2. *Physician assistants*
3. *Nurse practitioners*
4. *Clinical nurse specialists*
5. *Certified registered nurse anesthetist*
6. *Certified nurse-midwife*
7. *Clinical social worker*
8. *Clinical psychologist*
9. *Registered dietitian or nutrition professional*
10. *Physician or non-physician practitioner organizations (e.g., group practices) consisting of the individuals identified in 1 through 9 above (e.g., physician clinic).)*

In accordance with 42 CFR §424.525(a)(1) and (2), respectively, the contractor (including the NSC) may reject the provider's application if the provider fails to furnish complete information on the enrollment application, including all supporting documentation, within 30 calendar days from the date of the contractor's request for the missing information or documentation.

The 30-day clock identified in 42 CFR §424.525(a) starts on the date that the contractor mails, faxes, or e-mails the pre-screening letter to the provider. If the contractor makes a follow-up

request for information, the 30-day clock does not start anew; rather, it keeps running from the date the pre-screening letter was sent.

NOTE: *The contractor has the discretion to extend the 30-day time period if it determines that the provider or supplier is actively working with the contractor to resolve any outstanding issues.*

The contractor shall also note the following with respect to rejections:

- ***PECOS*** *– The contractor (with the exception of the NSC) shall create an L & T record for paper CMS-855 applications no later than 20 calendar days after receipt of the application in the contractor's mailroom. If the contractor rejects the application and was unable to create an L & T record due to missing data, the contractor shall document the provider file accordingly. If the contractor was able to create the L & T record but rejected the application, the contractor shall flip the status to "rejected" in PECOS.*

- ***Resubmission after Rejection*** *– If the provider's application is rejected, the provider must complete and submit a new CMS-855 and all supporting documentation.*

- ***Appeals*** *– The provider may not appeal a rejection of its enrollment application.*

- ***Policy Application –*** *Unless stated otherwise in this chapter, the policies contained in this section 3.1 apply to all CMS-855 applications identified in sections 2.1 and 2.2 above (e.g., changes of information, reassignments). Thus, suppose an enrolled provider submits a CMS-588. If any information is missing from the form, the contractor shall send a pre-screening letter to the provider.*

NOTE: *The NSC only collects the CMS-588 for initial DMEPOS supplier enrollment applications (CMS-855S). The NSC does not have to include the CMS-588 in any prescreening letter to a DMEPOS supplier that is not initially applying for a Medicare billing number.*

- ***Incomplete Responses*** *– The provider must furnish all missing and clarifying data requested by the contractor within the applicable timeframe. If the provider furnishes some, but not all, of the requested data within the applicable time period, the contractor is not required to contact the provider again to request the rest of the information. It can simply reject the application at the expiration of the aforementioned 30-day period.*

- ***Notice of Rejection*** *– If the contractor rejects the application under this section 3.1.1, it shall notify the provider via letter or e-mail that the application is being rejected, the reason(s) for the rejection, and how to reapply. The contractor is free to keep the original application on file after rejection. If the provider requests a copy of its application, the contractor may fax it to the provider.*

To summarize, if - during the pre-screening process - the contractor finds that data or documentation is missing, it shall send a pre-screening letter to the provider within the applicable 15-day (Internet-based PECOS applications) or 20-day (paper applications). The

provider must furnish all of the missing material or documentation within the applicable timeframe. If the provider fails to do so, the contractor may reject the application.

15.8.3 – Reserved for Future Use

(Rev.356, Issued: 09-24-10, Effective: 10-26-10, Implementation: 10-26-10)

15.8.4 – Denials

(Rev.356, Issued: 09-24-10, Effective: 10-26-10, Implementation: 10-26-10)

A. Denial Reasons

Per 42 CFR §424.530(a), contractors must deny an enrollment application if any of the situations described below are present, and must provide appeal rights.

When issuing a denial, the contractor shall insert the appropriate regulatory basis (e.g., 42 CFR §424.530(a)(1)) into its determination letter. The contractor shall not use provisions from this chapter as the basis for denial.

Note that if the applicant is a certified provider or certified supplier and one of the denial reasons listed below is implicated, the contractor need not submit a recommendation for denial to the State/RO. The contractor can simply: (1) deny the application, (2) close out the PECOS record, and (3) send a denial letter to the provider in a format similar to that which is used for carrier denials of non-certified supplier applications (see sections 24 and 25 of this chapter). The contractor shall copy the State and the RO on said letter.

Denial Reason 1 (42 CFR §424.530(a)(1))

The provider or supplier is determined not to be in compliance with the Medicare enrollment requirements described in this section or on the enrollment application applicable to its provider or supplier type, and has not submitted a plan of corrective action as outlined in 42 CFR part 488.

Note that this denial reason shall be used in the situations described in section 8.4.1, of this chapter.

Denial Reason 2 (42 CFR §424.530(a)(2))

The provider or supplier, or any owner, managing employee, authorized or delegated official, medical director, supervising physician, or other health care personnel of the provider or supplier who is required to be reported on the CMS-855 is—

- *Excluded from Medicare, Medicaid, or any other Federal health care program, as defined in 42 CFR §1001.2, in accordance with section 1128, 1128A, 1156, 1842, 1862, 1867 or 1892 of the Social Security Act, or*

- *Debarred, suspended, or otherwise excluded from participating in any other Federal procurement or nonprocurement program or activity in accordance with section 2455 of the Federal Acquisition Streamlining Act.*

Denial Reason 3 (42 CFR §424.530(a)(3))

The provider, supplier, or any owner of the provider or supplier was, within the 10 years preceding enrollment or revalidation of enrollment, convicted of a Federal or State felony offense that CMS has determined to be detrimental to the best interests of the program and its beneficiaries. Offenses include--

- *Felony crimes against persons, such as murder, rape, assault, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions.*

- *Financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions.*

- *Any felony that placed the Medicare program or its beneficiaries at immediate risk, such as a malpractice suit that results in a conviction of criminal neglect or misconduct.*

- *Any felonies outlined in section 1128 of the Social Security Act.*

While, as discussed in section 27.2(D), of this chapter, the contractor will establish an enrollment bar for providers and suppliers whose billing privileges are revoked, this in no way precludes the contractor from denying re-enrollment to a provider or supplier who was convicted of a felony within the preceding 10-year period or who otherwise does not meet all criteria necessary to enroll in Medicare.

Denial Reason 4 (42 CFR §424.530(a)(4))

The provider or supplier submitted false or misleading information on the enrollment application to gain enrollment in the Medicare program. (The contractor shall contact its DPSE contractor liaison prior to issuing or recommending denial of an application on this ground).

Denial Reason 5 (42 CFR §424.530(a)(5))

The CMS determines, upon onsite review or other reliable evidence, that the provider or supplier is not operational to furnish Medicare covered items or services, or does not meet Medicare enrollment requirements to furnish Medicare covered items or services. This includes, but is not limited to, the following situations:

- *The applicant does not have a license(s) or is not authorized by the Federal/State/local government to perform the services for which it intends to render. (In its denial letter, the contractor shall cite the appropriate statute and/or regulations containing the licensure/certification/authorization requirements for that provider or supplier type. For a*

listing of said statutes and regulations, refer to section 12 et seq. of this chapter. Note that the contractor must identify in the denial letter the exact provision within said statute/regulation that the provider/supplier has failed to comply with).

- *The applicant does not have a physical business address or mobile unit where services can be rendered and/or does not have a place where patient records are stored to determine the amounts due such provider or other person (as set forth in §1833(e) of the Social Security Act).*

- *The applicant does not meet CMS regulatory requirements for the specialty. (In containing the licensure/certification/authorization requirements for that its denial letter, the contractor shall cite the appropriate statutory and/or regulatory citations provider or supplier type. For a listing of said statutes and regulations, refer to section 12 et seq. of this chapter. Note that the contractor must identify in the denial letter the exact provision within said statute/regulation that the provider/supplier is not in compliance with).*

- *The applicant does not qualify as a provider of services or a supplier of medical and health services. An entity seeking Medicare payment must be able to receive reassigned benefits from physicians in accordance with the Medicare reassignment provisions in §1842(b)(6) of the Act (42 U.S.C. 1395u(b)).*

NOTE: *This denial provision should be used in cases where the applicant is not recognized by any Federal statute as a Medicare provider or supplier (e.g., marriage counselors).*

- *The applicant does not provide a valid SSN/EIN for the applicant, owner, partner, managing organization/employee, officer, director, medical director, and/or delegated or authorized official.*

- *A home health agency (HHA) does not meet the capitalization requirements outlined in 42 CFR §489.28.*

B. Denial Letters

When a decision to deny is made, the carrier shall send a letter to the supplier identifying the reason(s) for denial and furnishing appeal rights. The letter shall follow the format of that shown in section 24 of this chapter.

No reenrollment bar shall be established for denied applications. Reenrollment bars apply only to revocations.

C. Post-Denial Submission of Enrollment Application

A provider or supplier that is denied enrollment in the Medicare program cannot submit a new enrollment application until the following has occurred:

- *If the denial was not appealed, the provider or supplier may reapply after its appeal rights have lapsed.*

- *If the denial was appealed, the provider or supplier may reapply after it received notification that the determination was upheld.*

D. 30-Day Effective Date of Denial

A denial is effective 30 calendar days after the contractor sends its denial notice to the provider.

As stated in 42 CFR §424.530(c), if the denial was due to adverse activity (sanction, exclusion, debt, felony) of an owner, managing employee, an authorized or delegated official, medical director, supervising physician, or other health care personnel of the provider or supplier furnishing Medicare services, the denial may be reversed if the provider or supplier submits proof that it has terminated its business relationship with that individual or organization within 30 days of the denial notification.

E. Provider Enrollment Appeals Process

For more information regarding the provider enrollment appeals process, see section 25, of this chapter.

15.8.4.1– Denials for Incomplete Applications

(Rev.356, Issued: 09-24-10, Effective: 10-26-10, Implementation: 10-26-10)

This section 8.4.1 only applies to the following individuals and organizations that are submitting an initial application, a change request, or a reassignment:

1. *Physicians*
2. *Physician assistants*
3. *Nurse practitioners*
4. *Clinical nurse specialists*
5. *Certified registered nurse anesthetist*
6. *Certified nurse-midwife*
7. *Clinical social worker*
8. *Clinical psychologist*
9. *Registered dietitian or nutrition professional*
10. *Physician and non-physician practitioner organizations (e.g., group practices) consisting of the individuals identified in 1 through 9 above (e.g., physician clinic).*

In accordance with 42 CFR §424.530(a)(1), the contractor may deny the provider's application if the provider fails to furnish complete information on the enrollment application, including all supporting documentation, within 30 calendar days from the date of the contractor's request for the missing information or documentation.

The contractor has the discretion to extend the 30-day time period if it determines that the provider or supplier is actively working with the contractor to resolve any outstanding issues.

Note that the concept of "rejection" is no longer applicable to an initial application, reassignment, or change request that is submitted by any of the individuals or organizations identified in 1 through 10 above. Such applications must be denied, not rejected.

The contractor shall also note the following with respect to denials for the submission of incomplete applications:

- ***PECOS*** *– The contractor shall create an L & T record for paper CMS-855 applications no later than 20 calendar days after receipt of the application in the contractor's mailroom. If the contractor denies the application and was unable to create an L & T record due to missing data, the contractor shall document the provider file accordingly. If the contractor was able to create the L & T record but denied the application, the contractor shall flip the status to "denied" in PECOS.*

- ***Incomplete Responses*** *– The provider must furnish all missing and clarifying data requested by the contractor within the applicable timeframe. If the provider furnishes some, but not all, of the requested data within the applicable time period, the contractor is not required to contact the provider again to request the rest of the information.*

- ***Documentation*** *– The contractor shall document in the file the date on which it completed its pre-screening of the application.*

To summarize, if - during the pre-screening process - the contractor finds that data or documentation is missing, it shall send a pre-screening letter the provider within the applicable 15-day (Internet-based PECOS applications) or 20-day (paper applications) pre-screening period. The provider must furnish all of the missing material or documentation within the applicable timeframe. If the provider fails to do so, the contractor must deny the application.

15.8.4.2 – Adverse Legal Actions/Convictions

(Rev.356, Issued: 09-24-10, Effective: 10-26-10, Implementation: 10-26-10)

Unless stated otherwise, the instructions in this section 8.4.2 apply to the following sections of the CMS-855 application:

- *Section 3*
- *Section 4A of the CMS-855I*
- *Section 5B (Owning and Managing Organizations)*
- *Section 6B (Owning and Managing Individuals)*

The applicant shall furnish documentation concerning the type and date of the action, what court(s) and law enforcement authorities were involved, and how the adverse action was resolved. It is extremely important that the contractor obtain such documentation, regardless of whether the adverse action occurred in a State different from that in which the provider

currently seeks enrollment. In other words, all adverse actions must be fully disclosed, irrespective of where the action took place. In situations where the person or entity in question was excluded but has since been reinstated, the contractor shall verify this through the OIG and ask the applicant to submit written proof (e.g., reinstatement letter) that such reinstatement has in fact taken place.

If the applicant states in section 3, 4A of the CMS-855I, 5, and/or 6 that the person or entity in question has never had an adverse legal action imposed against him/her/it; but there is evidence to indicate otherwise, the contractor shall make a determination (approve or deny) or contact DPSE for further guidance. (See section 8.4 of this manual for further details on the handling of potentially falsified applications).

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

If the contractor denies an application or revokes a provider based on an adverse legal action, the contactor shall search PECOS (or, if the provider is not in PECOS, the contractor's internal systems) to determine: (1) whether the provider has any other associations (e.g., is listed in PECOS as an owner of three Medicare-enrolled providers), or (2) if the denial/revocation resulted from an adverse action imposed against an owner, managing employee, director, etc., of the provider, whether the person/entity in question has any other associations (e.g., a managing employee of the provider is identified as an owner of two other Medicare-enrolled HHAs). If such an association is found and, per 42 CFR 424.535, there are grounds for revoking the billing privileges of the other provider, the contractor shall initiate revocation proceedings with respect to the latter.

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

<u>Chain Home Offices, Billing Agencies, and HHA Nursing Registries</u>

If the contractor discovers that an entity listed in sections 7, 8, or 12 of the CMS 855 has had a final adverse action imposed against it, the contractor shall handle the matter in accordance with the instructions in this section 8.4.2.

15.17 – Establishing an Effective Date of Medicare Billing Privileges

(Rev.356, Issued: 09-24-10, Effective: 10-26-10, Implementation: 10-26-10)

(This section only applies to the following individuals and organizations: physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse-midwives; clinical social workers; clinical psychologists; registered dietitians or nutrition professionals; and physician and non-physician practitioner organizations (e.g., group practices) consisting of any of the categories of individuals identified in this paragraph.)

In accordance with 42 CFR §424.520(d), the effective date for the individuals and organizations identified above is the later of the date of filing or the date they first began furnishing services at a new practice location. Note that the date of filing for Internet-based PECOS applications for these individuals and organizations is the date that the contractor received an electronic version of the enrollment application and a signed certification statement.
In accordance with 42 CFR §424.521(a), the individuals and organizations identified above may, however, retrospectively bill for services when:

- The supplier has met all program requirements, including State licensure requirements, and

- The services were provided at the enrolled practice location for up to—

1. 30 days prior to their effective date if circumstances precluded enrollment in advance of providing services to Medicare beneficiaries, or

2. 90 days prior to their effective date if a Presidentially-declared disaster under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. §§5121-5206 (Stafford Act) precluded enrollment in advance of providing services to Medicare beneficiaries.

Medicare contractors shall interpret the phase "circumstances precluded enrollment" shown above to mean that that the physician, non-physician practitioner or physician or non-physician practitioner organization meets all program requirements, including State licensure, during the 30 days before an application was submitted and no final adverse action, as identified in 42 CFR § 424.502 precluded enrollment. If a final adverse action precluded enrollment during the 30 day period prior to date of filing, the Medicare contractor shall only establish an effective billing date the day after the date the final adverse action was resolved as long as it is not more than 30 days prior to the date the application was submitted.

15.31 - Provider Enrollment Fraud Detection Program for High Risk Areas

(Rev.356, Issued: 09-24-10, Effective: 10-26-10, Implementation: 10-26-10)

The PSCs shall identify an area as a potential high risk for provider/supplier enrollment and shall notify the A/B MACs and ACs, excluding the NSC, through the JOA process. High risk areas may be identified by emerging or widespread anomalies that may lead to potential fraud and abuse in, for example, claim type, provider type and geographic area. (See PIM, chapter 4, §§4.32 and 4.32.1 for additional information concerning the responsibilities of the PSC.)

After receiving and reviewing the information on the potential high risk areas the AC or the A/B MAC shall determine if the information is a high risk for provider/ supplier enrollment and, if so, provide a written request to the Director of the Division of Provider and Supplier Enrollment (DPSE), requesting approval that the area be designated as high risk. The request should include the name of the AC or the A/B MAC, a contact name, phone number and a justification for designating an area as high risk for fraud and abuse.

The A/B MAC shall notify its project officer of the request for designation as a high risk fraud and abuse area concurrent with the A/B MAC's request for approval to the Director of DPSE.

15.31.1 – Submission of Proposed Implementation Plan for High Risk Areas

(Rev.356, Issued: 09-24-10, Effective: 10-26-10, Implementation: 10-26-10)

Upon obtaining approval from the Director of the DPSE within the Program Integrity Group regarding the designation of a high risk area, the A/B MAC or AC shall submit, for approval, an implementation plan that addresses the problems identified in the high risk areas. The request shall include the name of the A/B MAC or AC, a contact name, phone number, and a description of the proposed action plan.

The A/B MAC or AC shall propose an implementation plan that includes, but is not limited to the following actions to remediate the identified problems in the high areas:

- *Conduct revalidation activities;*
- *Conduct unannounced site visits;*
- *Expand verification and validation activities to include felony searches for individuals, owners, managing officials, and delegated officials;*
- *Establish a risk assessment for newly enrolled providers/suppliers.*

The A/B shall work with its project officer in coordination with DPSE to determine the specific support functions needed for ongoing and proposed project activities.

If the A/B MAC or AC determines that a provider or supplier no longer meets Medicare enrollment standards, the MAC or AC shall follow the procedures set forth in section 13 of this chapter.