CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-08 Medicare Program Integrity	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 388	**Date: September 16, 2011**
	Change Request 7525

SUBJECT: Additional Review Activities for Home Health Agencies (HHAs)

I. SUMMARY OF CHANGES: As stated in CMS Publication 100-08, chapter 15, section 15.26.2(B)(3), the contractor must verify that a newly enrolling HHA has the required amount of capitalization after the CMS regional office (RO) review process is completed but before the contractor conveys Medicare billing privileges to the HHA. Accordingly, the HHA must submit proof of capitalization during this "post-RO review" period. This CR, however, also requires the contractor - during the post-RO review period - to review each entity and individual listed in sections 2, 5 and 6 of the HHA's CMS-855A application against the Medicare Exclusion Database (MED) (or the Office of Inspector General's (OIG) List of Excluded Individuals and Entities) and the General Services Administration Excluded Parties List System (GSA List).

EFFECTIVE DATE: December 17, 2011
IMPLEMENTATION DATE: December 17, 2011

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
N	15/15.26.3/Additional Review Activities

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: 388	Date: September 16, 2011	Change Request: 7525

SUBJECT: Additional Review Activities for Home Health Agencies (HHAs)

Effective Date: **December 17, 2011**

Implementation Date: December 17, 2011

I. GENERAL INFORMATION

A. Background: As stated in CMS Publication 100-08, chapter 15, section 15.26.2(B)(3), the contractor must verify that a newly enrolling HHA has the required amount of capitalization after the CMS regional office (RO) review process is completed but before the contractor conveys Medicare billing privileges to the HHA. Accordingly, the HHA must submit proof of capitalization during this "post-RO review" period. This CR, however, also requires the contractor – during the post-RO review period – to review each entity and individual listed in sections 2, 5 and 6 of the HHA's CMS-855A application against the Medicare Exclusion Database (MED) (or the Office of Inspector General's (OIG) List of Excluded Individuals and Entities) and the General Services Administration Excluded Parties List System (GSA List). This activity applies:

- Regardless of whether the HHA is provider-based or freestanding, and
- Only to initial enrollments

B. Policy: The purpose of this requirement is to ensure that the HHA is still in compliance with Medicare enrollment policies prior to the issuance of a provider agreement.

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	
7525.1	As stated in Publication 100-08, chapter 15, section 15.26.3, the contractor shall – during the post-RO review period described therein - review each entity and individual listed in sections 2, 5 and 6 of the HHA's CMS-855A application against the MED (or OIG list) and the GSA list.	X		X		X					
7525.1.1	The capitalization and MED/GSA re-reviews described above shall be performed once the RO notifies the contractor via letter or e-mail that the RO's review is complete.	X		X		X					

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7525.2	Once the contractor has completed the capitalization and MED/GSA re-reviews, it shall notify the RO of this via letter or e-mail.	X		X		X					
7525.2.1	The notice described in business requirement 7525.2 shall also specify: (1) whether the HHA is still in compliance with Medicare enrollment requirements, and (2) the date on which the contractor completed the aforementioned reviews.	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: N/A

Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
	N/A

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

V. CONTACTS

Pre-Implementation Contact: Frank Whelan, frank.whelan@cms.hhs.gov, (410) 786-1302.

Post-Implementation Contact: Contact your Contracting Officer's Technical Representative (COTR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: 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.

Section B: *For Medicare Administrative Contractors (MACs)*:

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

Medicare Program Integrity Manual
Chapter 15 - Medicare Enrollment

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(Rev.388, Issued: 09-16-11)

15.26.3 – Additional Review Activities

(Rev. Rev.388, Issued: 09-16-11, Effective: 12- 17-11, Implementation: 12-17-11)

As stated in section 15.26.2(B)(3) of this chapter, the contractor must verify that a newly enrolling home health agency (HHA) has the required amount of capitalization after the regional office (RO) review process is completed but before the contractor conveys Medicare billing privileges to the HHA. Accordingly, the HHA must submit proof of capitalization during this "post-RO review" period.

To further ensure that the HHA is still in compliance with Medicare enrollment requirements prior to the issuance of a provider agreement, the contractor shall – during the post-RO review period - also review each entity and individual listed in sections 2, 5 and 6 of the HHA's CMS-855A application against the Medicare Exclusion Database (MED) (or the Office of Inspector General's (OIG) List of Excluded Individuals and Entities) and the General Services Administration Excluded Parties List System (GSA List). This activity applies:

- *Regardless of whether the HHA is provider-based or freestanding*
- *Only to initial enrollments*

The capitalization and MED/GSA re-reviews described above shall be performed once the RO notifies the contractor via letter or e-mail that the RO's review is complete. Once the contractor has completed the capitalization and MED/GSA verifications, it shall notify the RO of this via letter or e-mail. Said notice shall also specify: (1) whether the HHA is still in compliance with Medicare enrollment requirements, and (2) the date on which the contractor completed the aforementioned reviews.

If:

- ***The HHA is still in compliance** (e.g., no owners or managing employees are excluded, capitalization is met), the RO will: (1) issue a CMS Certification Number (CCN), (2) sign a provider agreement, and (3) send a tie-in notice or approval letter to the contractor. Per CMS Pub. 100-08, chapter 10, section 5.5.3.1, the contractor shall complete its processing of the tie-in notice/approval letter within 21 calendar days of receipt.*
- ***The HHA is not in compliance** (e.g., capitalization is not met), the RO will: (1) notify the HHA and the contractor via letter of the denial of certification, and (2) afford appeal rights to the HHA. Upon receipt of this notice from the RO, the contractor shall switch the HHA's Provider Enrollment, Chain and Ownership System (PECOS) record to a "denied" status. (The denial date shall be the date on which the contractor completed the above-mentioned re-reviews.) The contractor, however, need not send a denial letter to the HHA or afford appeal rights; the RO performs these activities.*

While, therefore, the process of enrolling certified suppliers and certified providers other than HHAs will remain the same (i.e., recommendation is made to State/RO, after which the RO sends tie-in notice to contractor, etc.), the HHA process will now contain additional steps –

specifically, Steps 4 and 5, as outlined below:

1. *Contractor processes incoming HHA application and either (1) denies application, or (2) recommends approval to State/RO.*

2. *State performs survey (if applicable) and makes recommendation to RO.*

3. *If State recommends approval and RO concurs, RO will – instead of issuing CCN, signing provider agreement and sending tie-in notice/approval letter to contractor at this point, as is done with other certified provider and certified supplier applications – notify contractor that its review is complete.*

4. *Upon receipt of RO's notification, contractor will perform capitalization and MED/GSA reviews discussed in sections 15.26.2 and 15.26.3 of this chapter.*

5. *Once contractor completes its review, it will notify RO as to whether HHA is still in compliance with enrollment requirements.*

6. *If provider not in compliance, RO will deny certification and issue appeal rights, while contractor will switch PECOS record to "denied" once it receives notice of denial from RO. If provider is in compliance, RO will: (1) issue CCN, (2) sign provider agreement, and (3) send tie-in notice/approval letter to contractor.*